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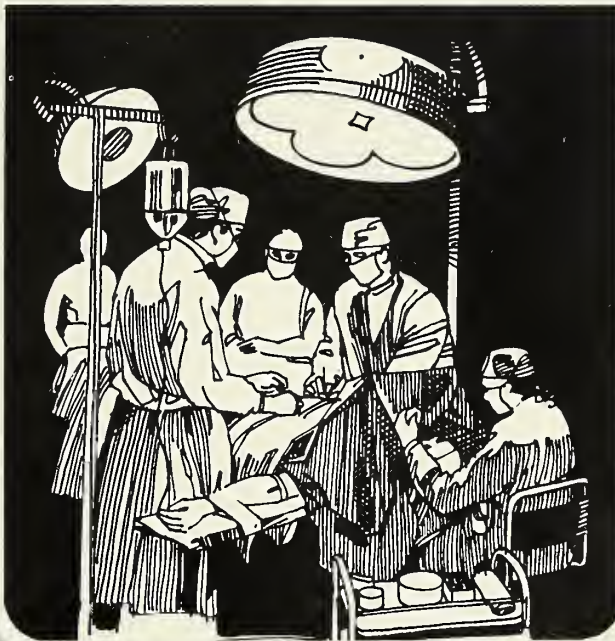
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JANUARY 1979

THE MESSAGE OF TENSION

HEADACHES

SWEATS

TENSE, TAUT MUSCLES

HYPERVENTILATION

TACHYCARDIA

PALPITATIONS

BURNING IN STOMACH

FULLNESS

FREQUENCY

to relieve psychic tension
and its functional symptoms

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(diazepam)^(M)

2-mg, 5-mg, 10-mg scored tablets

VALIUM[®] (diazepam)

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Indications: Tension and anxiety states; somatic complaints which are concomitants of emotional factors; psychoneurotic states manifested by tension, anxiety, apprehension, fatigue, depressive symptoms or agitation; symptomatic relief of acute agitation, tremor, delirium tremens and hallucinosis due to acute alcohol withdrawal; adjunctively in skeletal muscle spasm due to reflex spasm to local pathology; spasticity caused by upper motor neuron disorders; athetosis; stiff-man syndrome; convulsive disorders (not for sole therapy).

The effectiveness of Valium in long-term use, that is, more than 4 months, has not been assessed by systematic clinical studies. The physician should periodically reassess the usefulness of the drug for the individual patient.

Contraindicated: Known hypersensitivity to the drug. Children under 6 months of age. Acute narrow angle glaucoma; may be used in patients with open angle glaucoma who are receiving appropriate therapy.

Warnings: Not of value in psychotic patients. Caution against hazardous occupations requiring complete mental alertness. When used adjunctively in convulsive disorders, possibility of increase in frequency and/or severity of grand mal seizures may require increased dosage of standard anticonvulsant medication; abrupt withdrawal may be associated with temporary increase in frequency and/or severity of seizures. Advise against simultaneous ingestion of alcohol and other CNS depressants. Withdrawal symptoms (similar to those with barbiturates and alcohol) have occurred following abrupt discontinuance (convulsions, tremor, abdominal and muscle cramps, vomiting and sweating). Keep addiction-prone individuals under careful surveillance because of their predisposition to habituation and dependence.

Use in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy; advise patients to discuss therapy if they intend to or do become pregnant.

Precautions: If combined with other psychotropics or anticonvulsants, consider carefully pharmacology of agents employed; drugs such as phenothiazines, narcotics, barbiturates, MAO inhibitors and other antidepressants may potentiate its action. Usual precautions indicated in patients severely depressed, or with latent depression, or with suicidal tendencies. Observe usual precautions in impaired renal or hepatic function. Limit dosage to smallest effective amount in elderly and debilitated to preclude ataxia or oversedation.

Side Effects: Drowsiness, confusion, diplopia.

hypotension, changes in libido, nausea, fatigue, depression, dysarthria, jaundice, skin rash, ataxia, constipation, headache, incontinence, changes in salivation, slurred speech, tremor, vertigo, urinary retention, blurred vision. Paradoxical reactions such as acute hyperexcited states, anxiety, hallucinations, increased muscle spasticity, insomnia, rage, sleep disturbances, stimulation have been reported; should these occur, discontinue drug. Isolated reports of neutropenia, jaundice, periodic blood counts and liver function tests advisable during long-term therapy.



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President's Page

Two issues dominated the December session of the AMA House of Delegates — *national health insurance* and *chiropractic*. Iowa's delegates shared in these important considerations. And while honest differences of opinion did and do exist, a spirit of unity evidenced itself in the end.

The subject of chiropractic has been highly visible as a consequence of litigation in three different states. In considering these legal proceedings, the AMA House resolved it should "support the right of a physician to choose those persons whom he or she will accept as patients and also to exercise his or her choice by the terms of contractual arrangement with other physicians, medical groups, hospitals or other institutions."

Further, the House said the AMA should "continue to support a physician's right to freely choose those whom he (she) will serve in the absence of legal considerations to the contrary." Additionally, said the House, "the obligations which a physician has to provide information to a patient or another party are those required by customary good medical practice and law."

Finally, the delegates agreed, the AMA should "continue to warn the public of the hazards to health of entrusting the diagnosis and treatment of diseases such as cancer, diabetes . . . to practitioners who, in the treatment of these conditions, rely upon the theory that all disease is caused by misalignment of spinal vertebrae and can be cured by manual manipulation of the spine."

We need to remember that medicine's belief regarding chiropractic theory has changed little. However, the law has. Chiropractors are now licensed in all 50 states. They are entitled by law to engage in their occupation. Every physician must deal individually and independently with these circumstances.



Russ Gerard M.D.

Russell S. Gerard, II, M.D., President

SMF/IMS LOAN PROGRAM CONTINUES TO SERVE

JUST NOW ENTERING its second quarter century of service is the Scanlon Medical Foundation/Iowa Medical Society. This academic year the Foundation is loaning over \$34,000 to 16 Iowans attending medical school. These students come from such places as Monroe, Emmetsburg, Maquoketa, Urbandale, Waterloo and Sioux City.

In the 25 years since the Foundation was established approximately \$700,000 has been loaned to qualified Iowans aspiring to become physicians. These Foundation funds have continued to revolve as repaid money is circulated again in loans to current students.

Officially, the Foundation is described as a non-profit corporation to engage in, assist, further, promote and contribute to the support of

The Foundation first was known as the Iowa State Medical Society Educational Fund. In 1964 the name was changed to Iowa Medical Foundation. And in 1968 the present designation was authorized to honor George H. Scanlon, M.D., the organization's founder and a surgeon in Iowa City until his death in 1969.

Loans of up to \$2,500 per year are made to approved medical student applicants. The loan recipients must be Iowans, but they need not attend medical school in the state. Those interested in receiving loans must complete applications and submit to interviews with a physician member of the SMF/IMS Board.

In addition to the medical student loan program, several other projects have received sup-

PHYSICIAN RELIEF FUND

In 1966, as part of the total Scanlon Foundation program, a Relief Fund for Needy Physicians was established. This action was taken consistent with one of the Foundation's three stated purposes — to serve in charitable ways.

Financial support for the Relief Fund has existed for more than 10 years through the generosity of the late Henry Albert, M.D., an Iowa physician. In his will, Dr. Albert provided that

earnings from his estate be used to assist "needy physicians" or to support projects in the public health area.

This reference is provided as a reminder of the fund. A protocol has been established wherein the Foundation Executive Committee, when made aware of a situation where assistance may be desired, will counsel with the president or other representative of the appropriate county medical society to make a determination of the need. Inquiries on the Physician Relief Fund may be directed to the Headquarters of the Iowa Medical Society.

such charitable, educational and scientific activities and projects as are in general, either directly or indirectly, related to health or medicine.

More specifically, as a mechanism of the medical profession, the Foundation is here mainly to help deserving Iowans meet the financial requirements of medical school. The Foundation program got its start through an annual assessment of Iowa physicians. This lasted five years. Since then funds have been received voluntarily by the Foundation from Iowa practitioners and from various other sources. Certain monies — from county medical societies, medical specialty organizations and the Iowa Medical Auxiliary — have been loaned to the Foundation through the years for subsequent loan to medical students.

port from the Foundation. Included here are the Hawkeye Science Fair, the monthly Henry Albert Scientific Presentation in the JOURNAL OF THE IOWA MEDICAL SOCIETY, and the Baldrige-Beye Lecture at the IMS Scientific Session. Support has been given to various other health-related activities.

The Scanlon Foundation is guided by a Board of Directors. The 1978-79 Board is composed of J. H. Kelley, M.D., Des Moines; Hormoz Rassek, M.D., Council Bluffs; J. F. Bishop, M.D., Davenport; L. W. Swanson, M.D., Mason City; R. E. Hockmuth, M.D., Iowa City; G. L. Baker, M.D., Iowa City; R. V. Saf, Des Moines; Ivan Johnson, Des Moines; Mrs. R. J. Foley, West Des Moines, and E. E. Huston, Des Moines.

IN THE PUBLIC INTEREST

IOWA Medical Miscellany

JUNE IN TAN-TAR-A—1979 IMS SCIENTIFIC SESSION

For high-caliber continuing education, for relaxation, for good fellowship with physician colleagues, please set aside June 18, 19 and 20. The 1979 IMS Scientific Session is the event. The site is the Tan-Tar-A Resort in Osage Beach, Missouri.

A four-barrel CME program is now in place, thanks to good efforts by the 1979 Program Committee. Topics include Legionnaires Disease, Coronary By-Pass Surgery, Infection Control, New Antibiotics, The Problem Physician, Hepatitis, Federal Legislation, and on, and on.

The program and the facilities will be super. The recreational opportunities are abundant. Please consider the event. Material regarding reservations will be forthcoming.

POPULATION GROWTH . . . Iowa's population remains one of the oldest and slowest growing, according to new Census Bureau estimates. The current population estimate is 2,879,000, a growth of about 54,000 persons since 1970. The growth rate is the seventh lowest in the nation. Only Florida and Arkansas exceed Iowa (13%) in percentage of population over 65.

GENERAL ASSEMBLY . . . The state's legislative process resumes formally January 8. With 45 or more new lawmakers in both chambers, the session is likely to be slow in the early stages.

IMPAIRED PHYSICIAN . . . A special IMS ad hoc committee has been charged with deciding how the Society can structure a program to assist the impaired physician. Hormoz Rassekh, M.D., a Council Bluffs psychiatrist and Society Board member, will chair the committee. The subject has been under discussion several years. The first meeting of the new committee is January 18.

GENETIC & METABOLIC SCREENING . . . A newly-appointed ad hoc committee on genetic and metabolic screening will meet January 24. Purpose of the committee, which includes physicians from family practice, ob-gyn, pediatrics

and pathology, will be to review state proposals and make comments and recommendations.

HEALTH PLANNING . . . Efforts to assure optimum medical input are being pressed by the IMS in the development of standards and criteria to be used by Iowa HSA's in the Certificate of Need process. The concept of joint standards has been accepted by the 3 HSA's and the Statewide Health Coordinating Council. The IMS is fostering a collaborative attempt (involving the College of Medicine, Iowa Academy of Pediatrics, Iowa Academy of Surgery, Iowa Clinical Society of Internal Medicine, Iowa Chapter, American College of Radiology) to make sure physician expertise is included in the standards for CON review as they pertain to cardiac catheterization surgery and CT scanning. Also under evaluation and receiving IMS input are acute care hospital beds (their utilization and occupancy rates) and end-stage renal disease.

FOR INFORMATION . . . The Prouty Company, which serves as insurance administrator for the Iowa Medical Society, has installed a new WATS line. Physicians with inquiries may call toll-free 1/800/532-1105.

(Continued on page 10)

Your malpractice insurance is no place to gamble

Professional Liability insurance is one area where it pays to be certain. Certain that you have the most comprehensive coverage possible for your insurance dollar. By purchasing your insurance through your Iowa Medical Society sponsored program you can make the value of your dollar go further thanks to the mass buying power of the Society.

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Educationally Speaking



by R. M. CAPLAN, M.D.

P'S FOR THE NBME

Perhaps you once took one or several examinations, the "National Boards," prepared by the National Board of Medical Examiners. The NBME is the organization that also creates the FLEX exam used in recent years for medical licensure. Perhaps you took that test. The NBME is being asked increasingly to help prepare examinations for self-assessment and other exams for use by certifying boards as a part of the growing movement toward re-certification. The NBME realizes that many medical schools, licensing boards, governmental bodies and others have used data from National Board exams for purposes that were never intended by the NBME and in ways that are statistically and psychometrically indefensible. They would not like such errors to be perpetuated as they increase their activity in the arena of continuing education and re-certification.

At a recent meeting I was invited to voice my concerns about NBME's participation in CME. My concerns and recommendations centered on seven ideas, each starting with a P. I felt that any test instruments or sampling procedures of any kind that the NBME might devise should demonstrate clear relation to:

1. *Performance.* The test should measure what we care about — physicians caring for patients. Knowledge is necessary for good practice, but knowledge exams don't measure what doctors do. Even measuring competence, if we can, is not

enough because competence refers to what we *can* do, not what we do.

2. *Personal practice profile.* There are so many physicians whose practices are unique that, in an optimal world, we would evaluate each individual's performance in relation to that uniqueness.

3. *Problem-solving.* Not retention of information, but the application of information and skills to the solution of medical problems is what matters.

4. *Practicality.* An exam in the CME arena must deal minimally with theoretical issues and maximally with real-life concerns.

5. *Practicability.* Such exams should require a minimum of time, expense and individual hassle.

6. *Pleasing the participant.* If an exam has the previous five characteristics it will likely please a clinician, but I mean something in addition. The exercise should feel challenging, yet gratifying and instructive, giving the individual a sense of having participated in a learning and growth activity.

7. *Punishment.* The clear relationship should be one of avoidance. Because there must remain at least the possibility of failure, however, if a decision about licensure or certification hangs on it, there will always remain at least an implication of punishment. But proper consciousness of this dilemma will help. It will lead to a more suitable choice of items and an orientation effort that will reduce the sense of strain and threat. Item 7 will be minimal if items one through six are maximal.

This is a tough challenge. But, to paraphrase Robert Browning, "Man's reach should exceed his grasp, or what's an NBME for?"

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

IOWA MEDICAL MISCELLANY

(Continued from page 7)

EXCELLENT RESPONSE . . . 1979 IMS dues response was excellent in December. Second notices will be mailed in January. Member physicians are urged to forward their dues.

ELECTED . . . Creighton B. Wright, M.D., professor in the U. of I. Department of Surgery, has been named president-elect of the Association for Academic Surgery. There are 1,500 members who are multispecialty surgeons at academic centers.

ABORTION FUNDING . . . State funding for abortions for indigent women has declined dramatically as a result of new restrictions adopted this year by the Iowa General Assembly. The state paid for eight abortions in July, August and September, the first three-month period under the new law. Payment is possible now only when the doctor certifies the woman's life is in danger, the fetus is impaired, the pregnancy result from rape or incest, or the abortion is medically necessary after miscarriage.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma, Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence:* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSSAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

Product Information as of April, 1976

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy Jan. 20-21, 1977.

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SCIENTIFIC ARTICLES

Familial Mediterranean Fever

KENNETH RAPPAPORT, D.O.,
DEBORAH LARSON, D.O., and
ROY W. OVERTON, M.D.
Des Moines, Iowa

FMF can be an elusive diagnosis to confirm. Its presentation often mimics other more common disease entities. Psychologic counseling may be an effective adjunct in the treatment.

FAMILIAL MEDITERRANEAN FEVER is a syndrome first described by Sohar *et al* in the early 1960's. It is being recognized increasingly as a nosological entity. Although by no means a rare disease, Familial Mediterranean Fever (FMF) has not been recognized clinically because of its infrequent occurrence in this country and its restriction to those of Mediterranean ethnic origin.

FMF is an inherited autosomal recessive disease. It is marked by sporadic attacks of fever and short self-limited peritonitis, arthritis, or pleuritis and the appearance of amyloidosis. In phenotype I the attacks appear first — in phenotype II, the rarer variant, amyloidosis appears first.

There is no specific laboratory test to establish the diagnosis. FMF must be recognized by specific clinical criteria. The following points are to be emphasized:

1. Short attacks of fever recurring at varying intervals.
2. Painful manifestations in the abdomen,

chest, joints or skin associated with the fever.

3. Absence of any causative factor capable in itself of explaining the disease.

4. Amyloidosis clinically of the nephropathic type.

5. Features of autosomal inheritance.

6. Preference for people of Mediterranean origin, particularly those of Jewish, Armenian and Lebanese ancestry.

Occasionally the diagnosis of FMF is difficult. This is caused by lack of criteria or by confusion with more common clinical disorders. The following case report describes a patient with FMF. The diagnosis may have been obscured by a history of chronic drug and ethanol abuse and depression.

REPORT OF A CASE

A 56-year-old male of Lebanese and Armenian descent was admitted to Mercy Hospital, Des Moines, Iowa on 25 September 1977. His chief complaint was fever and "recurrent bronchitis." The patient stated he had recurrent attacks of fever lasting from 2 to 5 days for several years. He complained these febrile episodes were accom-

Dr. Rappaport is in the private practice of internal medicine in Des Moines. Dr. Larson is a resident in internal medicine at the William Beaumont Army Medical Center in El Paso, Texas. Dr. Overton is in the private practice of family medicine in West Des Moines.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS
THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF JANUARY 1979.

panied by diffuse abdominal pain, migrating arthritis, chills and profuse nocturnal diaphoresis.

Past medical history revealed over the past four years the patient had five admissions to Mercy Hospital for evaluation of fever of obscure origin. Each febrile episode lasted 48 hours with a fever spiking as high as 39.5 C p.o. These episodes were associated with generalized abdominal pain and guarding with non-specific abdominal findings. Numerous blood, urine and sputum cultures were normal. In addition, his SMA-12, RA factor, antinuclear antibodies, serum protein electrophoresis, eosinophil count, febrile agglutinins, cold agglutinins, acute and convalescent viral titers and serological studies for fungi, toxoplasmosis, rickettsia and parasites were normal. His PPD skin test was negative on two occasions, as were his sputum and urine cultures for acid-fast bacillus. Previous colon x-rays, upper GI series, small bowel x-ray, liver and lung scans, gallbladder x-ray and intravenous pyelogram were all negative.

Social history revealed a heavy smoker. The patient had also been hospitalized numerous times for depression and drug abuse. He had a history of antidepressant, tranquilizer and sedative abuse.

Upon admission the patient had a temperature of 39.0 C p.o. and coarse breath sounds. He also had nonspecific abdominal tenderness with a liver edge palpable 2 fingers below the right hypochondrium with a verticle span of 14 cm. There was no spider angiomas or palmar erythema. The remaining physical exam was normal. The hematocrit was 38.3%; the white cell count 15,400 with 80% neutrophils, 15 lymphocytes, 2 monocytes and 3 eosinophils. The erythrocyte sedimentation rate was 85 mm per hour. The urea nitrogen was 8 mg, the glucose 95 mg, the bilirubin .9 mg, and the protein 7.5 g (the albumin 4.4 g and the globulin 3.1 g) per 100 ml. The glutamic oxalocetic transaminase (SGOT) was 39 U and the lactic dehydrogenase (LDH) 226 U. The calcium was 4.7 millequivalents per liter, phosphorus 3.6 millequivalents per liter, cholesterol 181 mg/100 ml and uric acid 6.3 millequivalents per liter. The prothrombin time was 13 seconds with a control of 13 seconds and the PTT was 35 seconds with a control of 33 seconds. The platelet count was 242,000 per ml.

A liver biopsy demonstrated ethanol induced hepatic injury but no mallory bodies. Pulmonary function studies showed findings consistent with reversible large airway disease.

The patient was placed on colchicine 0.6 mgs TID and by the third hospital day the patient was afebrile and had normal white cell count. After psychological counseling the patient was dismissed to out-patient follow up.

DISCUSSION

A summary of the inheritance of FMF reveals it to be a disease in which males outnumber females in the proportion of 3:2. As a rule, its onset occurs primarily in the first decade of life with 90 per cent of the cases diagnosed by the second decade. It has, however, been diagnosed as late as 60 years.

Usually the patient will present with an attack of polyserositis (peritonitis, pleuritis or synovitis). Peritoneal attacks may vary from mild abdominal pain to that associated with marked distention and rebound tenderness. Board like rigidity, absence of peristalsis, multiple air fluid levels on abdominal x-rays, vomiting or leukocytosis may be present. Approximately 95% of patients with FMF will present with peritonitis.⁵

Pleuritis may present with pleuritic pain and diminished breath sounds. The chest film may show a small exudate which usually disappears in 48 hours. Pleural fluid is usually sterile with numerous polymorphonuclear leukocytes and mononuclear cells. As many as 40% of patients with FMF will have an attack of pleuritis.⁵

The arthritis is usually of short duration lasting one to seven days. The attacks are commonly monoarticular and involve the knee, ankle, hip and shoulder in decreasing frequency of appearance. Swelling, effusion, warmth and erythema may or may not be present. The articular component of FMF is the second most common manifestation in 75% of diagnosed patients.⁵

Attacks of an erysipelas-like rash are also common and occasionally will be the first clinical manifestation of the disease.¹ Sharply demarcated areas from 15 to 50 ce appear on the skin of the lower extremity usually distal to the knee. It is most commonly found on the lateral aspect of the ankle and dorsum of the foot. In Hellar's survey it was present in 27 of 74 patients with FMF.

Other miscellaneous signs and symptoms include pericarditis, hematuria, purpura, urticaria, angioneurotic edema, subcutaneous nodules and EEG abnormalities of a nonspecific nature.²

Special emphasis should be given to the so-called "periodicity" of the disease. The time intervals between successive attacks have been investigated in a large number of studies. Exacerbations and remissions are irregular, as it may be

months or years before the patient experiences a second attack. Therefore, it has been suggested by numerous authorities the adjective "periodic" be delineated from this clinical syndrome.⁵

As amyloidosis is the most significant prognostic finding in FMF special attention will be given to this matter. Present in approximately 25% of these patients, amyloidosis usually is present 5 years before it manifests itself clinically.

Amyloidosis manifests as proteinuria, nephrosis, and uremia. The appearance of the nephrotic syndrome is heralded by decreased serum albumin. Protein electrophoresis reveals normal or increased gamma globulins. The uremia phase is accompanied by hypertension, acidosis, hypocalcemia and often anemia.

The relationship between amyloidosis and polyserositis is unique. On one extreme, patients may show no signs of amyloidosis despite hundreds of attacks. On the other hand, the patient may manifest amyloidosis before experiencing a single attack. Renal failure is almost invariably the cause of death in those patients with amyloidosis.

Psychological aspects of the disease reveal that many patients have emotional instability, occasionally of a severe nature. It has been noted by some authors that drug addiction and depression are the most serious complications of the disease.⁶ Supportive psychotherapy and attention to the socioeconomic aspects of the disease are of great importance. Too often this aspect of the disease is overlooked by many physicians contributing to the under-diagnosis of the disorder.

Therapeutic modalities of FMF have been numerous in the past. Trials with a variety of antibiotics, vitamins, corticosteroids, antimalarials, psychotherapy, sympathectomy and various elimination diets have been tried.⁵

Current literature suggests that colchicine 0.6

to 1.8 mgms daily may be the drug of choice.^{1, 4, 7} Although there is evidence that colchicine interferes with cell migration and phagocytosis of human leukocytes in vitro, the exact mechanism of colchicine's action in patients with FMF remains unknown. While advertised as being highly effective in preventing attacks in susceptible patients, it has been estimated by various authorities that only 50 to 80% of afflicted individuals will respond to alempiric-trial of colchicine.^{2, 7}

CONCLUSION

Our patient suffered short attacks of fever recurring at varying intervals, painful discomforts in the abdomen, chest, back and joints along with absence of any causative findings despite an exhaustive work-up during multiple admissions. The patient's genetic heritage and overt drug and alcohol abuse, which is frequently seen in conjunction with this disease, supported the diagnosis. We should like to alert physicians to this mode of presentation and encourage recognition of the psychological component of FMF. In addition we should like to stress that polypharmacy in these patients should be replaced with intense psychological counseling devoting special attention to the emotional and socioeconomic problems seen concomitantly with this disease.

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March 7	Ophthalmology Clinical Conference

Mobile Coronary Care Unit

L. W. SWANSON, M.D., F.A.C.P., and

ARLENE JORDE, R.N.

Mason City, Iowa

This is a progress report on a mobile coronary care ambulance service started in 1971. The results of the program have been "heartening" and it is recommended for consideration by other communities.

A MOBILE CORONARY CARE ambulance service was established in Mason City in 1970. It was first reported in JOURNAL OF THE IOWA MEDICAL SOCIETY in September, 1971.¹ A resume of the activity was presented at the National Conference on Standards for Cardiopulmonary Resuscitation and Emergency Cardiac Care in Washington, D. C. in May, 1973. This latter report was published in the American Heart Association's conference proceedings.²

The previous reports explained the use of a stand-up ambulance with battery-operated portable oscilloscope, EKG machine and defibrillator, in addition to medications and intravenous fluids with oxygen, suction, etc., as provided by a local privately-operated ambulance service (Snell's).

On each call included in this subsequent study two ambulance attendants, plus a coronary care unit nurse from St. Joseph Mercy Hospital, were dispatched immediately to the patient. Two

groups of patients were studied. The first group were those within a radius of 25 miles of Mason City who called directly either the hospital or the ambulance service. The second group comprised patients taken to smaller area hospitals first, then transferred by the mobile coronary unit to the coronary care unit at St. Joseph Mercy Hospital. The transfer occurred after local diagnosis of suspected myocardial infarction, made sometimes with the aid of a telephone EKG reading service furnished by members of the St. Joseph Mercy Hospital staff. These have been referred to as transfer calls.

This service began on June 19, 1970. From that time until June 1, 1978, a total of 1,153 mobile coronary care unit calls have been made. Of these, 427 proved to be myocardial infarctions as judged by two of three criteria: 1) a good history; 2) definite EKG findings, and 3) enzyme and other laboratory confirmation. Initially, some calls were not reported to the ambulance service or to the hospital as heart calls. This meant patients were brought in by a regular ambulance with no cardiac monitor or coronary care unit

TABLE I
TIME FROM ONSET OF SYMPTOMS TO ARRIVAL OF MCCU
MCCU PRIMARY PATIENT CALLS — 542
APRIL 1, 1973 TO JUNE 1, 1978

	Under 1 hr.	1-2 hrs.	2-3 hrs.	3-4 hrs.	Over 4 hrs.	Unknown
	247	73	52	39	91	40
MI Mortality Rate —	1 — Under 1 hr.	0.5%				
	2 — 1-2 hrs.	1.1%				
	5 — 3-4 hrs.	2.7%				
	12 — Over 4 hrs.	6.4%				
	2 — Unknown	1.1%				
Total	22	11.8%				

Dr. Swanson is in the private practice of internal medicine in Mason City. Ms. Jorde is a clinical supervisor at St. Joseph Mercy Hospital in Mason City, Iowa.

nurse present. Three hundred and fifty-seven such calls were studied during this period of time, of which 68 proved to be definite myocardial infarctions.

REGULAR VS CORONARY

Two of those patients transported in the mobile coronary care unit expired in the ambulance, both of massive cardiac failure, not cardiac arrest. By contrast, nine of the 357 patients carried in the regular ambulance expired, most of them of cardiac arrest. This suggests an additional safety factor for the patient brought to the hospital in the coronary care unit.

Follow-up on 427 acute myocardial infarction patients brought to the hospital in the mobile coronary care unit showed an overall hospital mortality of 15.9%. Of these, 11.7% died in the coronary care unit and 4.2% died after release from the coronary care unit but before discharge from the hospital. Again, by contrast, of the 68 myocardial infarction patients brought to the hospital by regular ambulance, the overall hospital mortality was 39.7% — 27.9% in the coronary care unit and 11.8% in the hospital after leaving the CCU but before discharge.

All transfer patients from smaller hospitals were brought in by the mobile coronary care unit. There were 255 such patients, 152 of them with definite myocardial infarction. The overall mortality rate for these patients after reaching the hospital was 15.1% — 12.5% in the coronary care unit and 2.6% after leaving the coronary care unit.

HEARTENING RECORD

From April 1, 1973 to June 1, 1978 more detailed records have been kept. They show the nurse in the mobile coronary care unit defibrillated 56 patients on the way to the hospital without a single mortality in the mobile unit. This is an excellent record and a tribute to the skills of the coronary care unit nurses.

Beginning on April 1, 1973 effort was made to correlate mortality rates with the time of onset of the symptoms and the time of arrival of the mobile unit. In this effort, of the 542 patients brought in directly by ambulance, 247 were reached by the unit staff in under one hour's duration, 73 in between one and two hours, 52 in between two and three hours, 39 in between three and four hours, and 91 in over four hours. For another 40 it was not known how long their symptoms had occurred before treatment was begun by the mobile CCU staff. The mortality for these groups indicates

TABLE II
TIME FROM ONSET OF SYMPTOMS TO ARRIVAL OF MCCU
MCCU TRANSFER PATIENTS — 194
APRIL 1, 1973 TO JUNE 1, 1978

Under 1 hr.	1-2 hrs.	2-3 hrs.	3-4 hrs.	Over 4 hrs.	Unknown
45	29	27	22	52	18
MI Mortality Rate —					
		0	Under 1 hr.		0%
		0	1-2 hrs.		0%
		2	2-3 hrs.		1.7%
		3	3-4 hrs.		2.7%
		13	Over 4 hrs.		11.6%
		1	Unknown		0.9%
Total		19	16.9%		

those under treatment in less than one hour had an overall rate of .5%; one to two hours, 1.1%; three to four hours, 2.7%; and over four hours, 6.4%. The total mortality rate of this group was 11.8%. Two patients were uncertain as to the duration of the symptoms.

Of the transfer patients from smaller hospitals, 45 had symptoms less than one hour before the arrival of the mobile coronary care unit and the beginning of their treatment modalities, 29 between one and two hours, 27 between two and three hours, 22 between three and four hours, and 52 over four hours. Eighteen had an uncertain time interval. The mortality rate of those coming under treatment in less than two hours was 0%, those between two and three hours, 1.7%; those between three and four hours, 2.7%; and those over four hours, 11.6%. The total mortality of this group was 16.9%.

CONCLUSIONS

These figures suggest strongly the sooner a patient with acute myocardial infarction gets into the treatment pattern, the better off he is and the lower the mortality rate. Thus, patients suffering symptoms of acute myocardial infarction should be urged to get to a coronary care unit or at least a cardiac monitoring service as quickly as possible, preferably by means of a mobile coronary unit if one is available. It is hoped these figures will stimulate development of additional mobile coronary care units to furnish emergency cardiac service within the State of Iowa.

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Nephroptosis as the Cause Of Lower Abdominal Pain

MARVIN LEE JUNGLING, M.D.

Iowa City

A kidney which descends abnormally may sometimes cause lower abdominal pain. If the etiology of the pain is indeed a ptotic kidney, a nephropexy is indicated. Two cases illustrate this.

NEPHROPTOSIS should be considered in the differential diagnosis of recurrent dull lower abdominal pain. The most characteristic sign is the presence of a lower abdominal mass palpable only when the patient is erect. This is associated with symptoms of dull lower abdominal pain exacerbated by the erect position and relieved by recumbency.

In the 14th century Franciscus De Pedemontanus first described the movable kidney, but it was not until 1841 that Rayer delineated the characteristic associated symptoms.¹ Surgical treatment for nephroptosis varied from nephrectomy in 1878 to various suspension operations over the ensuing years. In the early 20th century there was inappropriate use of nephropexy as a cure for numerous maladies often unrelated to the movable kidney. The operation thus fell into dis-

repute. The mere presence of a ptotic kidney is not justification for nephropexy. However, the operation is useful when applied appropriately in well documented cases. These two cases illustrate the beneficial use of nephropexy.

CASE I

L. F., a 26-year-old gravida 0, para 0, white female, dependent wife of an Army officer was first seen in April 1974 for recurrent dull, right lower quadrant pain. Over the ensuing 15 months she was seen in numerous specialty clinics in the U. S. Army Hospital, including gynecology, gastroenterology and internal medicine. She was treated with various regimens without relief of her pain or diagnosis. A psychiatric consultation was contemplated. Diagnostic procedures included an oral cholecystogram, upper G.I. series, barium enema, liver and spleen scans, all of which were normal. CBC, urinalysis, urine culture, BUN, creatinine, protein electrophoresis, SGOT, alkaline phosphatase, LDH, bilirubin, amylase were also within normal limits. An intravenous urogram demonstrated mild caliectasis on the right with some fullness of the renal pelvis (Figure 1). She was referred to urology clinic. There was initial difficulty in relating her right lower quadrant pain to the findings on the routine intravenous urogram. On more careful questioning, she said her pain related to body position. It became progressively worse with activity in the upright position and was relieved by lying down. Significant medical history also included a voluntary 15 lb weight loss.

The author is in the private practice of urology in Iowa City. The paper was prepared during an association with The Department of Urology, Second General Hospital, Landstuhl, West Germany. The views expressed are those of the author and do not necessarily represent those of the United States Army or the Department of Defense.



Figure 1

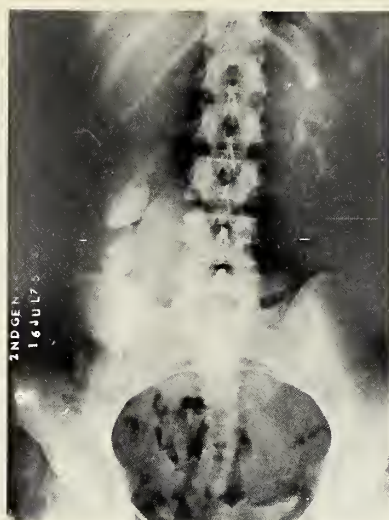


Figure 2

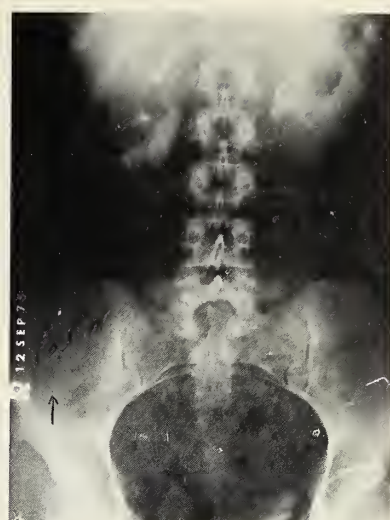


Figure 3

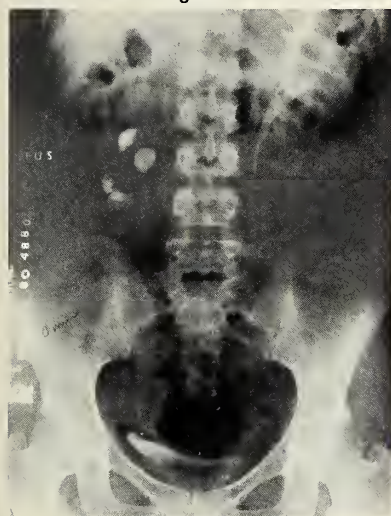


Figure 4



Figure 5



Figure 6



Figure 7

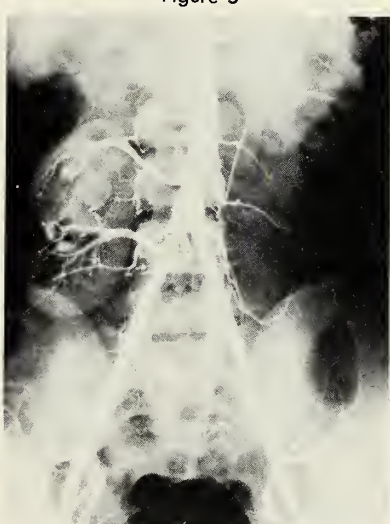


Figure 8



Figure 9

LEGEND — (1) Preoperative urogram. (2) Upright urogram with associated hydronephrosis. (3) Postoperative erect urogram. (4) Intravenous urogram showing under-rotated right kidney. (5) Right oblique view of Figure 4. (6) The erect intravenous urogram showing the fallen right kidney in the bony pelvis. There is no distention of the renal pelvis. (7) Oblique view showing again the pelvic position.

PHYSICAL EXAMINATION

Physical examination revealed a thin white female. Abdominal examination with the patient in the supine position was unremarkable. However, with the patient erect, a mobile right lower quadrant mass could be clearly felt. A repeat intravenous urogram with the patient erect confirmed the presence of a ptotic kidney with associated marked hydronephrosis (Figure 2). A right flank exploration revealed a very mobile kidney with a redundant renal pelvis and relative ureteropelvic junction obstruction exaggerated by the dependent position. A nephropexy and a Culp-Scardino flap type pyeloplasty were performed. Her postoperative course was uneventful and a follow-up erect intravenous urogram at six weeks was normal (Figure 3). She had a complete resolution of her symptoms and was a most appreciative patient.

CASE II

R. A., a 31-year-old white female wife of a staff sergeant had a 5-year history of intermittent right lower quadrant pain. She had an intravenous urogram performed in 1969, which revealed a ptotic right kidney, but this was discounted to be the cause of her pain. On careful questioning she described the pain as dull right lower quadrant pain, made worse by being erect and relieved by recumbency. She also observed interestingly the pain could be reproduced by lying on her left side or by straining in the sitting position. The only physical finding was a tender mobile right lower quadrant mass while standing erect. Routine laboratory values were normal, including a sterile urine culture. An intravenous urogram revealed the right kidney to be malrotated and inferiorly positioned (Figures 4 and 5). In the erect position, the kidney fell into the bony pelvis. There was no evidence of caliectasis or hydronephrosis to account for her symptoms (Figures 6 and 7). Thus, an arteriogram was performed to define the position and anatomy of the vascular structures (Figure 8). This study demonstrated two anomalously located renal arteries to the underrotated, but otherwise normal right kidney. Correlating the arteriogram with the intravenous urogram, it be-

came apparent there was torsion and tension on the renal vessels with descent of the kidney. A nephropexy was performed. The kidney was placed with the renal arteries perpendicular to the aorta, thus relieving the posture related tension on the pedicle. Her postoperative course was uneventful and she became completely free of pain. A postoperative erect intravenous urogram is shown in Figure 9.

COMMENTS

Nephroptosis is defined as a change in the kidney position of greater than one vertebral body from the supine to the upright position.² Both patients were symptomatic with recurrent right lower quadrant pain, but the mechanism of the symptoms differed. The first case demonstrated hydronephrosis and retention of urine as the cause of pain. In the second case, there was no evidence of hydronephrosis, but stretching and elongation of the nervus plexus around and along the renal pedicle was presumed to be the etiology of the pain. Nephroptosis is more common in women and more prevalent on the right side. The most common contributing factor to primary nephroptosis is the loss of perirenal fat,^{3, 4} such as in case No. 1, where the patient lost 15 pounds. The essential roentgenographic study is a comparison of the supine and upright intravenous urogram. Although nephroptosis is not a common cause of lower abdominal pain, this should be considered in the differential diagnosis, when a patient presents with typical signs and symptoms. In these two cases, careful questioning and examination of the patients led to the correct diagnosis and the definitive treatment. An earlier index of suspicion could have spared these patients the unnecessary expense of numerous procedures and frustrating delay in relief of their symptoms.

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Editorials

M. E. ALBERTS, M.D., Scientific Editor

A NEW YEAR

"Without a real desire to serve – no organization can grow beyond its own doorstep."

We enter a new year. Our thoughts turn to the future. Yesteryear is the past, and on the past we can base our projections for the future. Ours is a noble profession; our mission is to serve. As we help others we help ourselves, for in this service there is a satisfaction which defies description by mere words.

Resolutions for the new year may be trite, but we do project for the future and we hope our projections may be fulfilled. Recently, I came upon some resolutions in the form of thoughts to remember. I propose these 12 thoughts (perhaps one for each month) to guide us during the coming year. Let us not forget:

1. *The value of time.*
2. *The success of perseverance.*
3. *The pleasure of working.*
4. *The dignity of simplicity.*
5. *The worth of character.*
6. *The power of kindness.*
7. *The influence of example.*
8. *The obligation of duty.*

9. *The wisdom of economy.*
10. *The virtue of patience.*
11. *The improvement of talent.*
12. *The joy of originating.*

Our medical society has tremendous responsibilities. Individually, we are part of that society so it is incumbent upon each of us to be concerned and to act accordingly. Many decisions face us. Our concerns are with the needs of patients and the proper manner of service. We must demonstrate to those who wish great changes made in the delivery of health care that the patient may lose the most from such changes. Patients are people; people are taxpayers; and taxpayers must pay the bill when government intervenes. Our resolution for the future should be to maintain fairness and wisdom for the good of all. Greed and petty concerns about individual gain must give way to service for the good of all, for he who serves profits the most.

Our best wishes for a Happy New Year, and may our profession serve in the noble manner of the past for alleviation of pain and suffering to provide the best delivery of health care possible. Let us project ourselves as humanitarians, not as opportunists benefitting from the ill-health of suffering humans. — M.E.A.

READERSHIP OF MEDICAL JOURNALS

Journals published by state medical societies have enjoyed a good reputation over a long span of years. The state medical journals, as a group, are extremely well read. Member physicians read articles of individual interest and then look through the remaining pages quite thoroughly, thereby covering an entire issue reasonably well. These findings are of primary interest to potential advertisers. Obviously, it is through advertising reve-

nue that the state medical journals draw a portion of the sustenance needed to maintain their existence.

In July, 200 of our physician readers received a questionnaire from Health Industries Research, asking about their readership of the July issue of the IMS JOURNAL. Answers to the questionnaire were returned by 44 percent of the Iowa recipients. In the eight other states surveyed, the average completion rate of the questionnaires was 38 percent. We appreciate the "better than average" cooperation of our Iowa readers. The statistics

revealed that 94 percent of our members read at least one of every four issues, and 93 percent wish to continue receiving the JOURNAL.

The survey further sought to determine what features of a state medical journal are of the highest interest to readers. The reading level of various features or departments were ascertained and in our JOURNAL the following statistics emerged:

Feature/Department	Percentage Reading Level			
	All/Most	Selective	None	No Answer
Scientific Articles	21	76	2	1
Editorials	33	54	7	6
Question Box	18	49	22	11
President's Page	33	37	22	8
About Iowa Physicians	49	35	10	6

For these figures to emerge from a scientific sample of IMS JOURNAL readers, it is evident that at least some perusal is made of most of each issue. As a consequence, our advertisers should be gratified that their messages are being seen.

The State Medical Journal Advertising Bureau, of which we are a member, views the results of this new survey with substantial satisfaction. It demonstrates that state journals do represent a

good market for advertisers. Furthermore, the recent survey revealed a significant increase in readership over last year.

This report justifies a look at our future. The IMS JOURNAL is well-accepted and for that we are grateful and proud. We want to make it better and for that to come about we need your continued support and encouragement. The scientific articles presented to us are generally quite well done. We are anxious to receive concise, timely, interesting scientific presentations. If any reader wants to present an article on an economic or social aspect of medicine we welcome the opportunity to review this type of essay. We strive to generate new interesting aspects to our JOURNAL.

Are there any specific presentations desired by you the readers? Would articles with continuing medical education examinations be valuable? Are you interested in more material about the economics of medicine? Do you wish more information on health care delivery mechanisms? Do "Letters to the Editor" interest you? Reader input is welcome and receives all possible consideration. — M.E.A.

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State Department of Health

ADVANCED EMERGENCY MEDICAL CARE

The 1978 Iowa General Assembly passed Senate File 2076:

"An Act relating to the training and certification of and the services performed by advanced emergency medical technicians and paramedics, authorizing the Department of Health and the Board of Medical Examiners to make rules pursuant to this act with the advice of an advanced emergency medical care council, and imposing penalties."

This Act defines advanced emergency medical care as "such medical procedures as:

- a. Administration of intravenous solutions
- b. Gastric or tracheal suction or intubation
- c. Performance of cardiac defibrillation
- d. Administration of parenteral injections of any of the following classes of drugs: 1) antiarrhythmic agents, 2) vagolytic agents, 3) chronotropic agents, 4) analgesic agents, 5) alkalizing agents, 6) vasopressor agents, 7) anticonvulsive agents, and 8) other drugs which may be deemed necessary by the supervising physicians
- e. Any other medical procedure designated by the board (of medical examiners) by rule, as appropriate to be performed by advanced EMT's and paramedics who have been trained in the procedure."

A 12-member Advanced Emergency Medical Care Council was appointed by the State Board of Health as reported in the September issue of the JOURNAL. This Council has been drafting the rules for implementation of the law. The law divides the rule making and enforcement authority between the Board of Medical Examiners and the Department of Health. In general, the Board of Medical Examiners is responsible for certification of indi-

vidual advanced EMT's and paramedics. This includes: "requirements concerning prerequisites, training and experience for advanced EMT's and paramedics and procedures for determining when individuals have met these requirements." The Department is responsible for rules pertaining to the operation of ambulance services and rescue squad services which utilize the services of advanced EMT's or paramedics. This includes: "requirements concerning physician supervision, necessary equipment and staffing, and reporting by ambulance services and rescue squad services. . . ."

It is anticipated there will be three levels of advanced personnel; progressing in training and breadth of function from Advanced EMT-I to Advanced EMT-II to Paramedic. It is believed this will allow local areas to determine the level which best matches their needs and resources. It will also allow progression from one level to the next as physicians and advanced emergency medical care personnel grow in experience with the system and take additional training.

The proposed rules have progressed through several drafts. It is the goal of the Advanced Emergency Medical Care Council to have the proposed rules considered by the State Board of Health and the Board of Medical Examiners the second week of January, 1979. If this timetable is met and the rules are approved by those Boards, the rules will then enter the state rulemaking process. This will involve two reviews by the Administrative Rules Review Committee of the Legislature. There will also be a public hearing, probably at the end of February or beginning of March. Comments or input will be welcomed in the public hearing or in written form at any time prior to the hearing. Anyone desiring a copy of the proposed rules may request them from the Emergency Medical Services Section, Iowa State



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STATE DEPARTMENT OF HEALTH

(Continued from page 21)

Department of Health, Lucas State Office Building, Des Moines, Iowa 50319, telephone number 515-281-3741.

The success of any advanced emergency medical care system will depend on the leadership of local physicians. The law and the rules stress and insist upon "medical control" for the care of patients. If communities have physicians who are interested and willing to plan the local program, do the necessary training, provide direction and medical control at all times and evaluate the program, significant benefits will be realized. If physicians do not assume this leadership role it will not be possible to implement an advanced emergency medical care program. The Advanced Emergency Medical Care Council is confident there are many physicians throughout Iowa who are ready to accept this challenge. We look forward to working with you.

November 1978 Morbidity Report

Disease	Nov. 1978 Total	1978 to Date	1977 to Date	Most Nov. Cases Reported From These Counties
Amebiasis	13	158	104	Scattered
Brucellosis	2	17	23	Linn
Chickenpox	271	6268	8218	Scattered
Encephalitis, virol	1	29	11	Polk
Giardiasis	10	39	53	Scattered
Hepatitis, A	10	130	118	Scattered
Hepatitis, B	6	87	101	Dubuque, Johnson, Polk, Wright
type unspecified	5	52	37	Linn, Polk, Dubuque, Johnson
Herpes simplex	9	89	90	Scattered
Infectious mononucleosis	55	1040	1119	Scattered
Meningitis aseptic	6	53	30	Scott, Linn, Polk, Warren
bacterial	13	80	21	Scattered
Mumps	22	169	1358	Scattered
Pertussis	3	19	4	Buena Vista
Pneumonia	70	2329	1337	Scattered
Robies in animals	13	124	144	Scattered

Disease	Nov. 1978 Total	1978 to Date	1977 to Date	Most Nov. Cases Reported From These Counties
Rubella	5	69	177	Blackhawk, Dickinson, Polk
Rubeola (measles)	2	58	4316	Dickinson
Salmonella	16	181	274	Scattered
Shigella	8	64	91	Scott, Polk, Woodbury
Tuberculosis total ill	7	98	99	Wapello, Winnebago Winnebago, Pocahontas Hamilton, Polk, Scott
bact. pos.	7	73	83	Same as above
Venereal diseases:				
Gonorrhea	422	5076	5889	Scattered
P. & S. Syphilis	3	35	43	Johnson, Muscatine, Polk
Syphilis, total	31	218	264	Scattered
<i>Laboratory Virus Diagnosis Without Specified Clinical Syndrome: 2 —</i>				
<i>Adeno virus, Johnson; 1 — CMV, Linn; 1 — ECHO virus, type 4, isolated,</i>				
<i>Boone; 1 — ECHO virus, type 7, isolated, Soc; 1 — ECHO virus, type 17,</i>				
<i>isolated, Jackson; 1 each — Eton's agent, Blackhawk, Clinton, Linn and</i>				
<i>Hardin; 2 each — Eton's agent, Johnson, Fayette and Boone; 3 — Eton's</i>				
<i>agent, Polk; 1 — Coxsackie B-4, isolated, Scott.</i>				

About IOWA Physicians

Dr. Elmer Larsen, Centerville physician for more than 30 years, returned to Ida Grove recently to cover for **Dr. Dale Trombley**. After concluding his practice in Centerville, Dr. Larsen moved to Denver, Colorado. Last year Dr. Larsen joined Project USA, the national organization which provides doctors for rural areas, and has been filling in for vacationing physicians in Indiana, Kentucky and Iowa. . . . **Dr. James H. Coddington**, Humboldt, has been selected by the Catholic Youth Organization of St. Mary's Church to receive the 1978 CYO Citizen of the Year Award. The award is for outstanding community service. Dr. Coddington is a past deacon of the Congregational United Church of Christ; past president of the Humboldt County Chapter of the Iowa Heart Association and past president of the Iowa Academy of Family Physicians. . . . **Dr. Luis Garcia**, Mason City, spoke on plastic surgery at a recent meeting of the Mason City Chapter, American Association of Medical Assistants. . . . **Dr. Peter D. Wallace**, Iowa City, is new chairman of the Iowa Chapter, American Academy of Pediatrics. Other new officers include — **Dr. Martin G. Myers**, alternate chairman; and **Dr. Robert G. Thompson**, trustee. Dr. Wallace is in private practice in Iowa City. Drs. Myers and Thompson are associate professors in the Department of Pediatrics at U. of I. College of Medicine. . . . **Dr. David Ramsey**, Fairfield, left the Fairfield Clinic in November. He is returning to his native Texas where he will join a group practice in Mineral Wells.

Dr. Edson Knight, longtime Marshalltown physician, retired in October and **Dr. Pradeep Sarswat** has assumed his practice. A native of Bombay City, India, Dr. Sarswat recently completed a pulmonary fellowship at the Bronx Lebanon Hospital and Albert Einstein College of Medicine in New York City. . . . **Drs. Marvin L. Marcus** and **Richard E. Kerber**, associate profes-

sor and professor in Department of Internal Medicine at the U. of I. College of Medicine, were speakers at a recent cardiology seminar sponsored by Keokuk Area Hospital. The seminar focused on recent advances in non-invasive diagnosis of coronary artery disease. . . . Dedication ceremonies for the new North Iowa Medical Center, Regional Health Care Complex, were held October 21. The Center is located on the west edge of Mason City. . . . **Dr. Edward Farrage**, Council Bluffs, has received the 1978 St. Albert Catholic High School Award. Dr. Farrage was cited for his support of the high school and his contribution to the school's athletic program. A Council Bluffs physician since 1951, Dr. Farrage is the team doctor for the football squad. . . . **Dr. Reginald R. Cooper**, professor and head of the Department of Orthopaedics at the U. of I. College of Medicine, has been elected chairman of the National Easter Seal Research Foundation's Board of Trustees. . . . **Dr. Erling Larson**, Davenport, is the 1978-79 president of the University of Iowa Foundation. He has been a member of the Foundation Board of Directors six years and has served on its executive committee the last three years.

Dr. Leo V. DiCara, Keokuk, has been elected president of the Lee County Medical Society. . . . **Dr. John C. MacQueen**, professor in Department of Pediatrics at U. of I. College of Medicine, received the 1978 Clifford G. Grulee Gold Medal Award for outstanding service to the American Academy of Pediatrics at the AAP annual meeting in Chicago. Dr. MacQueen was recognized for his contributions to child health and his work in assisting AAP chapters to develop methods for child health planning. Dr. MacQueen is a past president of AAP. . . . **Dr. Thomas Riley**, otolaryngologist, has joined Ear, Nose and Throat Associates in Waterloo. Dr. Riley received the M.D. degree at the University

of Kansas Medical School; interned at Kansas City General Hospital Medical Center, Kansas City, Missouri, and received his general surgery and otolaryngologic training at the University of Kansas Medical Center and Albany Medical Center in Albany, New York. He recently completed a fellowship training program sponsored by the American Academy of Facial Plastic and Reconstructive Surgery.

Dr. Kent Opheim, Waterloo, recently was named a Fellow of the American Academy of Family Physicians. . . . **Dr. Patricia C. Connell** has joined the Black Hawk Area Family Practice Center in Waterloo. Dr. Connell received the M.D. degree at Temple University School of Medicine in Philadelphia, Pa.; and interned at Mayo Clinic in Rochester, Minnesota. She practiced emergency medicine two years at Andrew's Air Force Base in Washington, D. C., and has been in family practice five years in Rochester and Hayfield, Minnesota. . . . **Dr. Reuben Widmer**, associate professor in the U. of I. Department of Family Practice, received a \$100 award and plaque recently from the Society of Teachers of Family Medicine for a presentation at STFM annual meeting on "Depression in Primary Care:

Changes in Patterns of Patient Visits and Complaints During a Developing Depression." . . . **Dr. Abdul L. Chughtai**, Des Moines, was awarded Fellowship by the Council of Clinical Cardiology of American Heart Association during the recent AHA annual scientific sessions in Dallas, Texas. . . . **Dr. William Follows**, Spencer, was guest speaker at a recent meeting of the Spencer Hy-Noon Kiwanis meeting. Dr. Follows discussed joint replacements. . . . **Dr. Peter C. Black** has joined Drs. Rufus Kruse and Don Tyler to practice internal medicine in Marshalltown. Dr. Black received the M.D. degree at Western Reserve University School of Medicine in Cleveland, Ohio; interned in Spokane, Washington; and completed his internal medicine residency in San Francisco, California. Prior to locating in Marshalltown, Dr. Black was associated with VA Hospital in Des Moines.

Dr. Richard M. Freeman, professor in the Department of Internal Medicine at U. of I. College of Medicine and director of hemodialysis at the University of Iowa-VA medical centers, was elected vice president of the National Kidney Foundation at its recent annual meeting in New Orleans, Louisiana. Dr. Freeman is a founder of

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Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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It should be noted that the use of anticholinergic/antispasmodic drugs in the treatment of gastric ulcer may produce a delay in gastric emptying time and may complicate such therapy (antral stasis). Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSEAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg capsule and syrup: Adults: 1 or 2 capsules or teaspoonfuls syrup three or four times daily. Children: 1 capsule or teaspoonful syrup three or four times daily. Infants: ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg: Adults: 1 tablet three or four times daily. Bentyl Injection: Adults: 2 ml (20 mg) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1976

the Kidney Foundation of Iowa and served as its president from 1974-1976. . . . **Dr. Bernard F. Sand** and **Dr. Warren Nash**, Waterloo, and **Dr. Daniel J. Sullivan**, Marshalltown, recently were presented silver anniversary citations by Creighton University in Omaha, recognizing their 25 years of service to mankind and loyalty to Creighton. . . . **Dr. Charles Smith**, Muscatine, spoke at recent meeting of the Muscatine Rotary Club. Dr. Smith's topic "The Family Practice — What Does It Mean and How Could It Affect American Medicine." . . . **Dr. John W. Eckstein**, dean of the U. of I. College of Medicine, was installed recently as president of the American Heart Association at the organization's annual meeting in Dallas, Texas. . . . The fall meeting of the Iowa Clinical Surgical Society occurred at the Indiana University School of Medicine in November jointly with a meeting of the Indiana Chapter of the American College of Surgeons. Scientific papers were presented by the Surgical Department of Indiana University under the direction of **Dr. John E. Jesseph**, chairman and professor of the Department.

The late **Dr. Kirk H. Strong**, Fairfield, was honored at a recent Governor's Conference on Substance Abuse. The Iowa Commission on Substance Abuse announced the establishment of the Kirk H. Strong Award of Recognition. The award will be presented annually to the person who has shown exceptional involvement and achievement in the field of substance abuse prevention in Iowa. A plaque, noting the outstanding contributions of Dr. Strong to the Commission, was presented to the Strong family. . . . **Dr. Harley G. Feldick**, director of Student Health Services and team physician at U. of I., has been appointed a member of the American Medical Association's Advisory Panel for the Medical Aspects of Sports. . . . **Dr. Lester Proctor**, Oelwein, spoke on his recent trip to China at a recent meeting of the community's High 12 Club. . . . **Dr. Janusz Bardach**, professor in Department of Otolaryngology and Maxillofacial Surgery at U. of I. College of Medicine, was guest speaker at a recent workshop in Cedar Falls sponsored by Blackhawk Cleft Parents Association and the University of Northern Iowa speech pathology and audiology department. Dr. Bardach discussed coordination of professional efforts in patient care for parents of facial cleft children and professionals who deal with these problems.

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DEATHS

Dr. Otto N. Glesne, 79, Ford Dodge, died November 2 at Trinity Regional Hospital. Dr. Glesne received the M. D. degree at University of Minnesota School of Medicine and interned in Detroit, Michigan. He served as president of the Iowa Medical Society in 1962. He began his medical practice in Fort Dodge in 1926. He was a member of the Iowa Obstetrical and Gynecological Society; founding member of the American College of Obstetrics and Gynecology; and the North Central Medical Conference.

Dr. William Wolf, 59, West Union, died November 7 at his home. Dr. Wolf received the M.D. degree at U. of I. College of Medicine. One of the founders of the West Union Clinic, he began his practice of medicine in West Union in 1947.

Dr. Allen G. Felter, 88, Van Meter, died December 5 at Iowa Methodist Medical Center in Des Moines. Dr. Felter received the M.D. degree at U. of I. College of Medicine and began his practice of medicine in Van Meter in 1921. He was a past governor of Iowa College of Cardiology; fellow of the American College of Cardiology; and life member of the Iowa Medical Society.

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Medical Assistants



by BETTY EHLERT, CMA-A

RECORD NUMBER EARN CMA

A total of 2,693 certificates were awarded to successful candidates taking the spring 1978 certification examinations. The spring examinations were administered to 3,358 candidates at 122 test sites on June 2, 1978. Certified Medical Assistant certificates were awarded to 1,969 candidates who passed only the basic Certification Examination. In addition, specialty certification was awarded as follows: Administrative — 173; Clinical — 550; Administrative/Clinical — one. Many of those receiving specialty certification were first-time specialty candidates who also successfully completed the basic examination.

66 IOWANS CERTIFIED

The newly certified Iowa medical assistants are (all are CMA unless otherwise shown) named with their home community:

Deidre Anderson, Des Moines; Shirley Anderson, Sioux City; Condoce Arenholz, Clarksville; Cynthia Arneson, Decorah; Mory Ashlock, Cedar Rapids; Borboro Bieber, Anamosa; Linda Brown, Fort Dodge; Vicki Corlson, Modrid; Judy Collett, Essex; Nancy Cook, Lewis; Sherry Dennler, Slater; Pomelo Dentlinger, Lidderdale; Annette Dickey, Ankeny; Dione Dunkel, Worthington; Carol Esmoil, Muscatine; Julie Forren CMA-C, Colo.; Gole Fedler, Fort Madison; Morgoret Gardner, Waterloo; Noncy Genovese, Des Moines; Jonice Gossell, Corolville; Solly Groff, Grinnell; Movis Hockfort, Corroll.

Lori Honson, Eldora; Julie Hinton, Rockwell City; Rondo Hornbeck, Council Bluffs; Gwendolyn Jonsen CMA-A, Sioux City; Debbie Johnson, Red Oak; Morcello Kiertzner, Sioux City; Corolyn

CONTINUING EDUCATION

The primary purpose of AAMA is the professional advancement of medical assistants, medical assisting educators and students. Some continuing education services offered by the Association include Guided Study Programs. These professionally-designed home study courses enable medical assistants to learn at their own speed on their own time. "Anatomy, Terminology and Physiology" and "Human Relations" courses are available. Successful completion of examinations accompanying the Guided Study courses entitles the medical assistant to Continuing Education Unit (CEU) credit.

Lorson, Waterloo; Jill Lowton, Ames; Suson List, Council Bluffs; Peggy Lundy, Fontanelle; Kothryn Morsh, Cedar Rapids; Cotherine Meier, Lenox; Susan Metier, Des Moines; Kormen Milligon CMA-C, Boxter; Debro Moore, Burlington; Constance Nath, Hiawatha; Korleen Nieland, Corroll; Shirley Doneill, Corolville; Andreo Oppenheimer CMA-C, Emmetsburg; Kothy Perisho, Ames; Morcia Pickell, Modrid, and Jonice Pierce, Des Moines.

Beth Rohn, Bondurant; Poulo Roilsbock, Council Bluffs; Joyce Rou, Defiance; Shoryl Reese, Des Moines; Peggy Rhodes CMA-AC, Fort Dodge; Donno Rice CMA-C, Davenport; Debro Rogers, Osage; Shoron Root, Cedar Rapids; Anne Ryon, Persio; Down Sontman, Dysort; Cothy Sayles, Council Bluffs; Lindo Scheinback, Des Moines; Peggy Schultz CMA-C, Burlington; Kristi Stewart, Rutland; Deborah Simpson, Odebolt; Sue Stiefel, West Burlington; Auro Suddeth, Des Moines; Dione Touke, Cedar Rapids; Morgoret Tetley, Leon; Paula Williams CMA-C, Waterloo; Lucindo Wilson, West Liberty; Jonice Wolford, Doyton, and Marleo Wood, Adel.

Congratulations to the newly certified medical assistants!

SCOTT MARKS 20 YEARS

Scott County chapter members enjoyed a 20th birthday anniversary party in September at the

Davenport Outing Club. Nancy Winter was chairman of the party. The Scott County chapter was founded in 1958 with Jeanne Greene (Immediate Past National AAMA President) as the first president of the Chapter.

CLASSIFIED ADVERTISING RATE—\$1 per line, \$10 minimum per insertion. NO CHARGE TO MEMBERS OF IOWA MEDICAL SOCIETY. Copy deadline—10th of the month preceding publication.

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PHARMACIST — Seeking professional clinic in which to locate. Have Masters Degree in Hospital Pharmacy. For additional information, please write No. 1532, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

Presidential Thoughts On Cost Containment



We've been discussing inflation, specifically its impact on health care, at various county medical society meetings the past two or three months. It's been worthwhile to share information on what's happening in Iowa and nationally relative to this complex issue. We've received interesting comments from many physicians.

The federal government is a major contributor to our inflationary woes. It's spent 440% more dollars in the past 10 years. Still, the administration is now talking loudly about fiscal restraint within its own ranks. It's also admonishing the private sector to hold to 7% in cost, wage and price hikes.

Health care economics demand and deserve our attention. We've been told Iowa medical (physicians') charges are up 62% in five years. While this isn't 440% it still needs our evaluation. We must demonstrate — to the administration and to the public — we can act voluntarily and responsibly in this inflationary era.

Where Iowa departs from the norm we must determine why. We must make changes where appropriate. For example, if inpatient admissions have dropped nationally by 4% since 1972, why have they increased by almost 10% in Iowa? If inpatient days have dropped 12.5% nation-

ally, why have they declined by only half-a-percent in Iowa since 1972? We've got to look at the reasons.

This is the purpose of the Voluntary Effort, VE for short. The Iowa Voluntary Cost Containment Committee is pressing the VE cause in Iowa. We've been advised about 68% of the state's hospital beds are located in facilities which are certified as VE cost-containment facilities.

So far, VE seems to be working in Iowa and nationally. Congressional leaders say it *must* if mandatory controls are to be avoided. We must continue our progress in 1979. Bullet-biting efforts may salvage what remains of our unfettered practice environment. It's up to you and me.

A handwritten signature in cursive script that reads "Russ Gerard".

Russell S. Gerard, M.D.

Iowa medical society

VOL. 69, No. 2

FEBRUARY 1979

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REFRESHER COURSE FOR THE FAMILY PRACTITIONER FEBRUARY 13 TO 16

The 1979 Refresher Course for the Family Practitioner will occur in Iowa City February 13 to 16 under sponsorship of the University of Iowa College of Medicine, the Department of Family Practice and the Iowa Academy of Family Physicians.

The Course is accredited for 25 hours by the American Academy of Family Physicians and for Category I credit toward the AMA Physicians' Recognition Award. Full information is available from the Office of Continuing Medical Education, U. of I. College of Medicine, Iowa City, Iowa 52242. Telephone: 319/353-5763.

This Annual Refresher Course will provide family physicians a stimulating and practice-oriented opportunity to learn what's new in medical thinking, and to brush up on what's old. Among the program topics are — *Safe Use of Five Cardiac Drugs*, *Controlling Swimmer's Ear*, *Birth Control Pills: Which for Whom?*, *Which Medicine for Which Depression?*, *Low Back Trouble*, *Diabetes — Diet, Pills and/or Shots*, and the *Latest Word on the Latest Antibiotics*, plus a "Dear Abby" panel discussing: *Use of Marijuana*, *Teenage Pregnancy*, and patient problems of attending physicians.

The 1979 Refresher Course for the Family Physician will include a faculty of more than 75 persons. Included in the program will be brief lectures, panels, small discussion groups, question and answer periods, lunch with the experts, etc., in what is described as a "fast moving and practical educational experience." The program begins at 8:15 a.m., Tuesday, February 13, and continues until adjournment at 1 p.m., Friday, February 16.

Because the Joint Commission on Accreditation of Hospitals is now requiring hospital staff members to attain annual certification in basic cardiopulmonary resuscitation, but more importantly, because it makes sense to be current in this important skill, those attending the refresher course will have opportunity to become certified in CPR.

The Question Box

by ROBERT J. KETELAAR, M.D.

IPA IN IOWA

Dr. Ketelaar is a Davenport pathologist. He has served recently as chairman of a special 8-member committee from the Scott County Medical Society which has been joined by a corresponding body from Rock Island County, Illinois. This 16-member committee came into existence when Deere and Company, a major employer in the Quad-Cities, proposed establishment of an IPA-HMO. A report (with recommendations) from the committee was presented to both county societies at their January meetings. Dr. Ketelaar comments here on the consideration to date of an Individual Practice Association (IPA) Health Maintenance Organization (HMO).

Describe briefly the approach to health care delivery being considered in the Quad Cities area?

The impetus for investigating changes in the current system of health care came from Deere and Company, which employs approximately 15,000 persons in the Quad-Cities. Deere is self-insured for the health care benefits it provides to its employees. In late 1977 Deere established a Department of Health Care to bring these benefits under a central administration. Early in 1978 Deere reported the total cost of its health benefits had tripled in five years and had increased faster than any other company cost. Deere acknowledged that increased employment was partly responsible and the company had greatly increased benefits in contract negotiations with the UAW. Nevertheless, the company felt it must do something to contain the escalating costs and to give some degree of predictability to its health care expenditure. The Kaiser-Permanente Advisory Service did a feasibility study and reported a closed panel HMO would be legally and financially feasible in the Quad-Cities; Employers

of Wausau did a study and reported an IPA-type of HMO would be feasible. Under the IPA approach, the Quad-Cities physicians would form an Individual Practice Association which would contract with the HMO for the provision of medical services. Deere favored the IPA approach because it would be the least disruptive to patients and physicians alike. And all physicians would be eligible to join the plan while continuing to provide care in their individual offices.

What steps have been followed in bringing this consideration to its present point?

When Deere presented the proposal for an IPA-HMO to both medical societies in September, both groups directed that a special committee investigate the concept, along with other alternatives. We formed a joint committee of 16 members — 8 from Scott County and 8 from Rock Island County — with 6 doctors from the so-called primary care specialties and the remaining 10 from 7 other specialties. At the outset the committee had widely disparate attitudes, ranging from one who was strongly in favor of the concept to a few who were pretty negative. The committee covered a cross-section of attitudes in the medical societies. Our medical society office first gathered extensive information with assistance from the IMS and Iowa Foundation for Medical Care, among others. We obtained philosophical and practical papers on cost containment and various types of delivery systems around the country. About two-and-a-half pounds of reading material was provided each committee member to start the investigation. In November we made visits to operational IPA's in Springfield, Ill., Ft. Collins, Colo., Wausau, Wis., and Minneapolis, Minn. We attended an IPA seminar in Chicago. We also heard presentations from Inter Group Prepaid Services and from Blue Cross of Iowa. On December 14 the committee met to assess all we had seen and heard. We found surprisingly our dis-

(Please turn to page 56)

Educationally Speaking



by R. M. CAPLAN, M.D.

THE TOUGH ICEBERG

Allen Tough, a professor of adult education in Toronto, has conducted some major studies dealing with the way that adults study and learn. In a recent report he reviewed studies dealing with the amount of learning effort that adults engage in. He found that adults spend a remarkable amount of time each year in major efforts to learn. A typical learning effort requires about 100 hours; the typical adult engages in about five such projects a year. Some are formal and rely on instructors in classes, but almost 80% are planned by the individuals or rely upon friends and peer groups.

A learning project is defined as a highly deliberate effort to gain and retain certain definite knowledge and skill, or to change in some other way. There must be a series of related learning sessions in which the person's primary intention was to learn, and those must add up to at least seven hours.

Professor Tough found that for most people about 20% of all learning projects are planned by a professional, but in the other 80% the day-to-day planning is handled by an amateur. In 73% among the 80% it is the learner himself. This information leads Professor Tough to draw the analogy of an iceberg. We tend to focus on the highly visible, *professionally directed* portion of the (adult edu-

cation) iceberg which projects above the water. The massive bulk of that iceberg, however, is less visible but turns out to constitute about 80% of the adults' learning efforts. If that does not surprise you, perhaps it is because your own experiences and apportionment of efforts are similar.

One research project studied in detail how a learner plans his effort. The first step is to clarify a general problem or issue. Then an awareness of a deficit needs to develop which prompts the learner to begin a learning project. Then long-term or general objectives are established. Finally, the learner identifies and obtains learning resources. All of those introductory steps are usually present. The most common difficulties faced by those studied were knowing how to start the learning projects or set the objectives, finding or making time to learn (scheduling), and knowing whether or not they were progressing or had accomplished what they set out to do.

Some contend that efforts should be given to make more visible the immersed portion of the learning iceberg, for example, give credit to more varieties of individual work. That would serve useful purposes and might motivate occasional individuals to do more, or to work at their learning tasks in a more efficient way. But I doubt that giving credit of any formal sort, as a motivator for physicians or any other adults, will replace the urge for individual learning that grows out of one's personal (professional, if you like) sense of a need to learn and improve.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

1979 LEGISLATIVE INFORMATION AVAILABLE

Society members are advised certain legislative information is available on request from the IMS: (1) copies of bills, (2) status reports, (3) committee

members, and (4) legislators' home and office addresses. A Society booklet has been compiled which contains info on Iowa legislators.



SCIENTIFIC ARTICLES

Primary Hypothyroidism: A Case Report

RALPH R. PRAY, M.D.

Des Moines, Iowa

CASE REPORT

History. This is a case report on a 33-year-old white housewife and registered nurse seen in consultation March 13, 1975. She was referred by her dentist because of prolonged gingival bleeding from a partial tooth extraction. She had bled for over 32 hours with oozing and excessive clot formation. She had not had excessive bleeding after a tonsillectomy in childhood, but had noticed menorrhagia in recent months. She attributed this to an intrauterine device.

The medical history revealed no known drug allergies. She had undergone no surgical operations, except the tonsillectomy. She had the usual childhood diseases without complication. She was not on any medications. She had never had a serious injury.

The review of systems revealed she was gravida

An interesting case of primary hypothyroidism is described. A brief review is presented of the history, incidence, classification, treatment, etc., of the disease.

2, para 2, aborta 0, and had an uncomplicated normal spontaneous vaginal delivery of a healthy infant six months earlier. During the last trimester of that pregnancy, and even more since then, the patient experienced fatigue and muscular weakness to the point where she required a daily nap; was barely able to lift her children, then ages three years and six months, respectively; and was hardly able to climb stairs. She had gained five pounds compared to her prepregnancy weight and was unable to lose weight despite the fact she consumed only 800 calories per day. She and her family had attributed these symptoms to postpartum depression. She had complained of cold intolerance for several years, but this had become very severe the winter just preceding her examination. She described this as being "painful" and "chilling to the bone." Often, even when dressed warmly, she would have paroxysms of prolonged shivering upon even brief exposure to a cold draft or the frigid winter air. She had noted that her

The author is in the private practice of internal medicine in Des Moines, Iowa.

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AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF FEBRUARY 1979.

face was becoming "puffy," particularly below her eyes. Otherwise, the review of systems was not remarkable.

The family history was noncontributory, as both parents and a brother were in good health. The patient's husband and two children were also healthy.

The social history revealed the patient occasionally smoked cigarettes and rarely drank alcoholic beverages.

Physical Examination. The physical examination revealed a well-developed, well-nourished, young white female in no distress. The blood pressure was 90/60, pulse 64 and regular, height 67 inches and weight 127 pounds. The complete physical examination, including the examination of the heart and lungs, was not remarkable. The thyroid gland was not palpable. The pelvic examination was not repeated, as this had been done by her obstetrician four months earlier, and this had been negative with the intrauterine device in place at that time.

Laboratory Data. The urinalysis was negative. The complete blood count revealed a hemoglobin of 13.2 gm %, hematocrit 39%, white blood cell count 6500 and a normal differential count. The platelet count was 342,000/mm³. The erythrocyte sedimentation rate was 13 mm per hour. The prothrombin time was 12 seconds with a control of 12, and the partial thromboplastin time was 30 seconds with a control of 22. The bleeding time (Ivy) was prolonged at six minutes. An SMA 12 chemistry profile was within normal limits, including a serum cholesterol of 188 mg %. The serum thyroxine level (T4) was low at 2.5 µg %. The thyroxine level was repeated March 25, 1975, and found again to be low, this time at 2.8 µg %. The level of thyroid stimulating hormone (TSH) was found to be elevated at 76 µU/ml; the upper limit of normal for this test is 10 µU/ml.

Diagnosis and Treatment. The patient was thus diagnosed as having primary hypothyroidism. Treatment was initiated with thyroxine (Synthroid) 0.05 mg daily and the dose was doubled every two weeks until a dose of 0.2 mg per day was reached. One month later, May 10, 1975, the level of TSH was retested and found to yet be elevated, this time at 35 µU/ml, so the dose of thyroxine was increased to 0.3 mg daily.

The patient returned again for follow-up on October 3, 1975. She had been taking thyroxine (Synthroid) 0.3 mg every morning. At that time, the complete blood count revealed a hemoglobin

of 11.9 gm %, hematocrit 36%, and white blood cell count of 4,100 with 45% polys, 43% lymphocytes, 8% monocytes, 3% eosinophils, and 1% basophils on the differential count. The bleeding time (Ivy) had decreased to two minutes, and the cholesterol had decreased to 113 mg %. The serum thyroxine (T4) was 8.8 µg % and the thyroid stimulating hormone (TSH) level was recorded at 0.9 µU/ml.

At each increment in the increase of her thyroid hormone replacement therapy, the patient had noted a lessening of her fatigue and weakness. She had no further problems with cold intolerance or excessive bleeding, and the puffiness of her face had resolved.

REVIEW

Historical Perspective. The concept that cretinism was due to the absence of the thyroid was first formulated by Dr. C. H. Fagge at Guy's Hospital in 1871. Gull described adult myxedema in 1874. The term "myxedema" (mucous edema) was coined by Ord in 1878. Over the next four to five years, several investigators found that post-operative myxedema, or progressive strumipriva, developed after thyroidectomy for goiter. Murray in 1891 was the first to note the striking effects of therapy; he administered glycerine extract of animal thyroid. The next year, 1892, MacKenzie and Fox noted that animal thyroid was equally effective by mouth. Standardization of dessicated thyroid was introduced into the United States Pharmacopoeia in 1915. Synthetic L-thyroxine was introduced in 1953, after a feasible method of synthesis was formulated by Hems and associates. T3, liothyronine, followed thereafter.

Incidence. Myxedema occurs in one out of 1,500 hospital admissions. Adult myxedema is five times more frequent in women than in men. This disorder most frequently occurs between the ages of 30 and 60 years.

Classification. Hypothyroidism may be classified as primary, secondary or tertiary. The primary causes are due to the absence or dysfunction of the thyroid gland itself. The secondary causes are due to abnormalities of the anterior lobe of the pituitary gland and a resulting deficiency of thyroid stimulating hormone. The tertiary causes are due to certain abnormalities of the hypothalamus, resulting in a lack of thyrotropin releasing factor.

The primary causes may be nongoitrous or
(Please turn to page 50)

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(Continued from page 48)

goitrous. The nongoitrous varieties may be idiopathic, postablative, or postinflammatory. The idiopathic, or primary, variety is fairly common, and is characterized by atrophy of the thyroid gland. The thyroid gland may be ablated either surgically or with radioactive iodine. Thyroid function may decrease after Hashimoto's thyroiditis, and anti-thyroglobulin antibodies may be present. The goitrous causes may be due to congenital or hereditary defects, which are rare, or they may be acquired. They may be due to an excess or lack of iodides, or to drugs such as thiocyanates, para-amino salicylic acid, butazolidine, or due to cobalt. Natural goitrogens in food or milk may be causative. Thyroiditis is often goitrous and may lead to a deficiency of thyroid hormone.

Secondary hypothyroidism is due to pituitary failure, transport abnormalities within the pituitary portal system, or, hypothetically, to utilization defects. The latter cause has not yet been proven.

Certain abnormalities of the hypothalamus result in a deficiency of thyrotropin releasing factor, TRF, causing tertiary hypothyroidism.

The patient in this case report had primary, idiopathic, or essential hypothyroidism, as there was no history of thyroid surgery, radioactive iodine administration, drug intake, goiter, or tenderness of the thyroid gland. Her elevated TSH ruled out secondary or tertiary hypothyroidism. The level of serum thyroxine and thyroid stimulating hormone were determined initially to make and confirm the diagnosis of primary hypothyroidism, and retested subsequently at intervals to determine the adequacy of the thyroid hormone replacement therapy.

Gradation. The clinical picture of hypothyroidism varies according to its severity. Hypothyroidism is graded into overt, mild, subclinical, or with only antithyroid antibodies present without any other clinical or laboratory abnormalities. This patient probably had mild hypothyroidism for at least several months, but had worsened to the overt grade by the time the diagnosis was made.

Laboratory Findings. The laboratory abnormalities associated with hypothyroidism, besides the abnormalities of thyroid hormone levels, thyroid stimulating hormone, and antithyroid antibodies include a prolonged bleeding time due to decreased platelet adhesiveness, a normochromic, normocytic anemia, and an elevation of the serum cholesterol level. Even though this patient's platelet count was normal, her bleeding time was prolonged initially. In fact, she presented for evaluation of a suspected disorder of hemostasis. Her bleeding time became normal when she was on adequate thyroid replacement therapy. This patient was not anemic. Her serum cholesterol decreased from 188 mg % before, to 113 mg % with therapy.

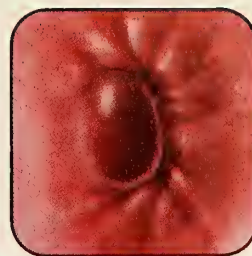
Differential Diagnosis. Hypothyroidism must be differentiated from mongolism, particularly in infants, and from chronic nephritis, especially nephrosis, and pernicious anemia.

Treatment. The treatment of hypothyroidism is with thyroid hormone replacement therapy. Thyroxine is the drug of choice because of its uniform potency. The potency of dessicated thyroid may vary from batch to batch. Thyroxine has a longer half-life in the circulation than liothyronine and gives a smoother clinical response, without a roller coaster effect due to peaks and valleys in the level, as would be more likely to occur with T3. The dosage of thyroxine is adjusted according to the patient's clinical response and according to the levels of T4 and TSH on therapy. TSH is the most sensitive test for primary hypothyroidism, as it is often elevated even in subclinical cases. The dose of thyroxine should be increased to bring the level of TSH down to less than 5 or 10 μ U/ml, as a level below 5 μ U/ml is the normal range for most laboratories and the level between 5 and 10 μ U/ml is considered equivocal. Most patients require only between 0.1 and 0.2 mg of thyroxine to achieve a full therapeutic effect, but the patient reported here, according to her clinical findings and TSH level, required a higher dose, 0.3 mg of thyroxine.

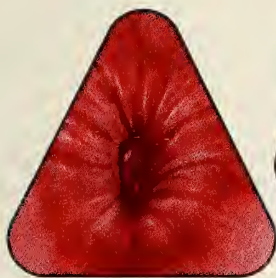
REFERENCES

The author has compiled a group of selected references to accompany this paper. These are available either from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

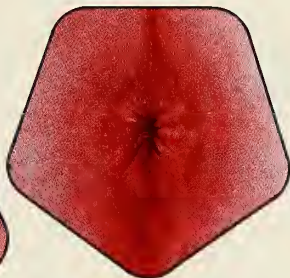
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Infection Following Classical Cesarean Section: An Indication for Early Hysterectomy

FRANK J. ZLATNIK, M.D.

JAMES R. SCOTT, M.D.

Iowa City, Iowa

ALTHOUGH CLASSICAL CESAREAN SECTION is indicated in unusual circumstances (e.g. transverse lie of a large fetus without development of the lower uterine segment; previous bladder surgery such as the repair of a vesicovaginal fistula, and carcinoma of the cervix), low cervical cesarean section is the procedure of choice in almost all other situations in modern obstetrics. Despite the fact this has been the accepted obstetric opinion for at least a generation, classical cesarean sections are still performed routinely by certain physicians in the rural midwest and perhaps in other parts of the country. The severity of infection following classical cesarean section has long been recognized. Because the majority of U. S. physicians now practicing have had minimal experience with classical cesarean sections, it is appropriate to re-emphasize that which was learned long ago, namely, that infection following classical cesarean section represents a different threat to the patient than does infection following low cervical or extraperitoneal cesarean section. The primary physician or consulting physician in these cases must recognize the severity of this problem

Dr. Zlatnik is associated with the Department of Obstetrics and Gynecology at the University of Iowa College of Medicine. Dr. Scott, formerly at the U. of I., is now located at the Department of Obstetrics and Gynecology at the University of Utah Medical Center.

The hazardous nature of uterine infection following classical cesarean section is illustrated and the need for aggressive antibiotic and surgical therapy in these cases is emphasized.

and must be prepared to institute vigorous antibiotic and surgical therapy.

Over the past decade we have been impressed by the morbidity exhibited by the one or two patients per year referred to University of Iowa Hospitals with infection following classical cesarean section, as is illustrated by the following case histories.

SELECTED CASES

Case 1 — Patient J.S.

This 31-year-old gravida 1, para 1, was transferred to the University of Iowa Hospitals six days following a classical cesarean section performed for cephalopelvic disproportion. The patient presented with premature rupture of the membranes of uncertain duration, had labored for 16 hours, and was apparently infected at the time of delivery. The fetus was stillborn. Ampicillin was administered postoperatively.

On admission here the patient was febrile, her abdomen was distended, and she had direct and rebound tenderness. The patient was emotionally unstable and, despite repeated discussions with several physicians, she refused the operation for nearly one month following her admission. During this time multiple antibiotics (cephalothin,

gentamycin, clindamycin, chloramphenicol) were administered. She remained febrile for most of this period, had abdominal pain, ate poorly, was distended, and had diarrhea. Finally, she consented to operation and a large intra-abdominal abscess was drained. The classical incision in the uterus was noted to be infected and open. However, because of extensive adhesions between bowel and the pelvic organs, further surgery was not undertaken. Following surgery she slowly improved and was discharged 21 days postoperatively (56 days following delivery).

The patient was next seen at this institution two years later when she arrived by ambulance. She was approximately 30 weeks pregnant, had abdominal pain with signs of peritoneal irritation, and was in shock. At exploration the placenta protruded from her ruptured classical scar. There were 2½ liters of blood and clot in the peritoneal cavity. A living immature fetus was delivered (the baby died neonatally) and a hysterectomy was performed. A postoperative ileus spontaneously resolved and the patient was discharged on the 12th postoperative day.

Case 2 — Patient A.W.

This 33-year-old gravida 8, para 8, was transferred to University Hospitals six days following a classical cesarean section performed for umbilical cord prolapse. She had not labored, but the membranes had ruptured 36 hours prior to delivery, and the patient had apparent uterine infection at the time of surgery. She had been treated with penicillin and then cephalothin at the referring hospital. On admission the patient was febrile and disoriented, her abdomen was tender and she was oliguric. She was placed on ampicillin and gentamycin and two days after admission, she was explored. At laparotomy generalized peritonitis was noted; the classical incision was purulent and necrotic. A subtotal hysterectomy was performed and the pelvis drained. The cervix was not removed because of difficulties with bleeding and adhesions on the left side. Her post hysterectomy course was one of slow improvement. Differing antibiotic regimens were used including anaerobic coverage with clindamycin and later chloramphenicol. Four weeks following hysterectomy she became more febrile. Re-exploration revealed an abdominal wall abscess which was drained. She improved and was discharged 12 days following this second procedure (58 days following delivery).

Case 3 — Patient L.H.

This 43-year-old gravida 6, para 4, was transferred to University Hospitals 15 days following a classical cesarean section and bilateral oophorectomy performed because of failure of descent of the presenting part due to inlet obstruction by ovarian tumors. Her labor had been brief and she was not infected at the time of operation. Hysterectomy was not done. Her postoperative course was complicated by fever and ileus. She had been treated with penicillin and then carbenicillin.

On admission the patient was febrile, markedly distended, had direct and rebound tenderness, and appeared critically ill. Following institution of ampicillin, gentamycin, and clindamycin therapy, she underwent exploratory laparotomy. The uterine incision was gaping and multiple pelvic and interloop abscesses were present. A hysterectomy was performed, abscesses were drained, and bowel was decompressed, and the abdomen was closed with flank and vaginal drains in place. The patient remained critically ill. Six days postoperatively a massive upper gastrointestinal hemorrhage mandated reoperation. Gastric ulcers were oversewn and an upper abdominal abscess was drained. The patient suffered a cardiorespiratory arrest one day after this procedure. She was resuscitated, but anoxic brain damage had apparently occurred and she died seven days later (29 days following delivery). An autopsy revealed peritonitis with adhesions, multiple peritoneal abscesses, and bilateral pneumonia.

DISCUSSION

Uterine infection following classical cesarean section is a different process from that which follows low cervical cesarean section. In the latter situation, if uterine infection develops, although the incision may become infected, this area is isolated from the peritoneal cavity by the bladder flap. Even if peritoneal contamination occurs at surgery, there is usually no continued bacterial seeding of the peritoneal cavity from the uterine incision. The bladder flap is not under tension and generally localizes the infected material extraperitoneally. However, in an infected uterus with a classical incision, no such protection exists. The infected uterine incision is often disrupted, permitting free egress of the infected intrauterine contents into the peritoneal cavity. Generalized peritonitis with ileus occurs and multiple intra-

(Please turn to page 55)

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(Continued from page 53)

abdominal abscesses may develop. The three patients reported above were febrile, distended, and had direct and rebound tenderness. Because of the laxness of the abdominal wall following delivery, peritonitis can exist in these patients in the absence of abdominal wall rigidity.

Just as the infectious process following cesarean section is of a different nature, depending on the location of the uterine incision, its treatment also differs. The treatment of uterine infection following low cervical cesarean section is primarily medical. On our service, antibiotic therapy with ampicillin or cephalothin, with or without an aminoglycoside, would be employed initially. Culture reports or failure to improve in 24 to 48 hours would influence us to increase anaerobic coverage with clindamycin or chloramphenicol. In our experience, most patients respond to such therapy. Even if they remain febrile, they often look and feel quite well. However, pelvic cellulitis may be slow to resolve, pelvic thrombophlebitis may require heparin, and one must always keep "drug fever" in mind. To be sure, some of these patients may require exploration and hysterectomy (e.g. clostridial infection, gram negative septic shock, an infected myoma, or pelvic abscess). However, this is most unusual.

One must view the patient with uterine infection following classical cesarean section from an entirely different perspective. This patient has, or will have, generalized peritonitis with continued seeding from the classical incision. Prompt vigorous antibiotic therapy including first line gram negative and anaerobic coverage should be employed. If the patient is not markedly improved in 24 to 48 hours, prompt abdominal hysterectomy with transabdominal and transvaginal drainage should be performed. Time is not an ally so long as the infected uterus remains in situ. Earlier hysterectomy may have improved the outcome in the cases presented above. Our failure to remove the uterus at the time of exploration in Case 1 nearly resulted in a maternal death in the subsequent pregnancy.

The problem of infection following classical cesarean section would be minimized if classical sections were performed only when indicated. The problem of uterine rupture in subsequent pregnancies would be minimized as well. It was not the indicated operation in any of the three patients presented here. Although two of these three patients had apparent uterine infection at the time of their initial surgery, concomitant hys-

terectomy was not performed.

The problem of infection following classical cesarean section is not unique to Iowa. Two of our three cases were referred from a neighboring state. Sandmire,¹ in reviewing maternal mortality in yet another midwestern state, found three of 19 maternal deaths, due to infections of all types during a 10 year period, occurred following cesarean section. All three of these patients had had classical uterine incisions.

If a physician performs an indicated classical cesarean section, he/she must remember the potentially lethal infectious complications and must consider hysterectomy at the time of section. This is reasonable therapy in the older multipara and in the clinically infected patient, regardless of parity. If a classical cesarean section is performed on a potentially infected patient (e.g. following a long labor or prematurely ruptured membranes) and if the uterus is not removed, then vigorous antibiotic therapy is indicated. If the patient subsequently manifests clinical infection, one must remember that early hysterectomy may be life-saving.

REFERENCE

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QUESTION BOX

(Continued from page 45)

parate attitudes had jelled into a unanimity of opinion. We discovered the committee members were convinced an IPA-HMO is a good way to practice cost-effective medicine without harming the quality of care. While there are differences as to structure, the committee voted unanimously to form an IPA-HMO. A subcommittee drafted a recommendation for the members.

Has the medical community been directly involved?

Not really, up to this point. The entire medical society membership heard the proposal in September, but subsequent involvement has been by the joint study committee. We gave progress reports at society meetings in November and December. We indicated the more we studied the more favorably we were inclined toward the IPA-HMO. We gave our full report at the medical society meetings in January and, after lengthy discussion, both societies authorized us to develop an IPA-HMO model for their consideration.

Does it appear likely the project will be fully approved and implemented in 1979?

We have no target date for implementation. We will take whatever time is necessary to do it right. We want to avoid the problems which developed in some of the plans we visited. We want a plan which has the greatest assurance of acceptability and success. There are myriad details, such as make-up of the HMO board and its interrelationship with the IPA, determination of the benefits package, actuarial and legal work, securing of a superior staff and data system for effective management. A subcommittee of six doctors is now working on these matters and will present a model when possible, but we have no timetable.

I should also add while Deere and Company did a lot of the groundwork and was the catalyst which got the project going, this will not be a Deere and Company HMO. Deere does not intend and the physicians do not want it to be a company HMO. It will be a community HMO with its board composed of physicians and other providers, representatives of other businesses and industries, and others in the community.

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence.** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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Pacemaker Induced Diaphragmatic Contractions

ABDUL L. CHUGHTAI, M.D.,
JAVAD YANS, M.D., and
MANMOHANLAL KWATRA, M.D.
Des Moines, Iowa

A case is reported where diaphragmatic contractions are precipitated by displacement of a permanent subendocardial pacemaker electrode. A brief review of the literature is presented, along with a discussion of the mechanism of diaphragmatic contractions.

THE IMPLANTATION of permanent transvenous pacemakers is well established in the management of patients having high-grade atrioventricular block with Stokes-Adams seizures, symptomatic bradycardia, cardiac arrhythmias, and various cardiac diseases. The long-term, battery-driven pacemaker, inserted via thoracotomy, was introduced in the United States in 1960 by Chardack,¹ Zoll,² and Kantrowitz.³ In 1959, Furman and Schwedel⁴ first used the subendocardial catheter through an antecubital vein and connected it to an external pulse generator. Later on, other veins were used with the entire system being placed subcutaneously. A number of complications have been reported in the literature relevant to the implantation of cardiac pacemakers. Most frequently cited are infection, electrode displacement, electrode fracture with loss of pacemaker function, myocardial perforation, and a rise in pacing threshold.

Dr. Chughtai is a cardiologist associated with Mercy Hospital in Des Moines. Drs. Yans and Kwatra are staff members in the Division of Cardiology, Department of Internal Medicine, Veterans Administration Hospital, Des Moines.

Diaphragmatic contractions have been reported occasionally, both with epicardial^{5, 6} and endocardial pacemakers.⁷ The case of diaphragmatic contractions reported here is associated with displacement of the electrode. The case will be discussed with a brief review of the literature.

CASE REPORT

An 81-year-old white male was admitted to the Veterans Administration Hospital, Des Moines, Iowa, May 16, 1976, with swelling of the left hand of one week duration. There was no indication of trauma. Past medical history included a cerebral vascular accident with right hemiparesis in 1969, diabetes mellitus, essential hypertension, arteriosclerotic heart disease, emphysema, status postoperative transurethral resection of prostate, and bilateral above-the-knee amputations.

Physical examination showed a thin old man, bilateral amputee, in no acute distress. His pulse was 48 per minute and regular; blood pressure was 200/50 mm Hg. There was no jugular venous distension at 45°. The heart sounds were faint and breath sounds were diminished.

An electrocardiogram on admission showed complete heart block with idioventricular rhythm at a rate of 48 per minute. (See Figure 1.) The chest x-ray revealed moderate cardiomegaly with mild pulmonary congestion. The laboratory data revealed a BUN of 39 mg percent; serum creatinine of 1.9 mg percent; the CBC and serum electrolytes were within normal limits.

In view of the complete heart block and left ventricular failure, a temporary pacemaker was inserted through the right arm which was replaced by a permanent transvenous demand pacemaker from the left subclavian vein. Meanwhile, the rhythm returned spontaneously to

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sinus with 1:1 atrioventricular conduction and the original pattern of right bundle branch block and left anterior hemiblock. The swelling in the left hand spontaneously resolved and the patient was discharged June 8, 1976. He was to continue receiving Lanoxin 0.25 mg and Dyazide one tablet daily.

The patient returned to the hospital June 14, 1976. His wife stated the patient developed contractions of the right upper abdominal muscles the preceding evening, as well as numerous hiccups. The patient denied any history of dizziness. Physical examination revealed right diaphragmatic contractions at a rate of 71 per minute. His pulse was 75 per minute and regular.

An electrocardiogram revealed sinus rhythm at a rate of 75 per minute with right bundle branch block and left anterior hemiblock. There was pacemaker artifact at 71 per minute without capture. (See Figure 2.) A provisional diagnosis was made of myocardial perforation with displacement of the electrode and stimulation of the right side of the diaphragm. However, a chest x-ray showed the electrode was twisted around the pulse generator and the tip of the electrode was in the superior vena cava. (See Figure 3.)

The patient was advised to have the electrode repositioned but he refused. The pacemaker was removed and he was monitored continuously for three days. He was found to be in sinus rhythm except for periods of sinus bradycardia during sleep at night. He was discharged on 10 mg Isuprel tablets sublingual at night besides Lanoxin 0.125 mg PO and Lasix 40 mg PO daily.

The patient was seen on October 4, 1976, in the outpatient clinic without having any symptoms. An electrocardiogram showed sinus rhythm with right bundle branch block and left anterior hemiblock, as before.

DISCUSSION

Diaphragmatic contractions have been reported as a complication of both epicardial and subendocardial pacemakers. Sprinkle, *et al*⁵ first described the contractions of the left diaphragm in association with an epicardial pacemaker. This was related to stimulation of the left phrenic nerve produced by uninsulated myocardial electrodes. In the case described by Peleska and Buda,⁶ the diaphragmatic contractions were related to faulty insulation of one of the two myocardial electrodes. The diaphragmatic contractions were abolished after the conversion of the bipolar system to a unipolar system.

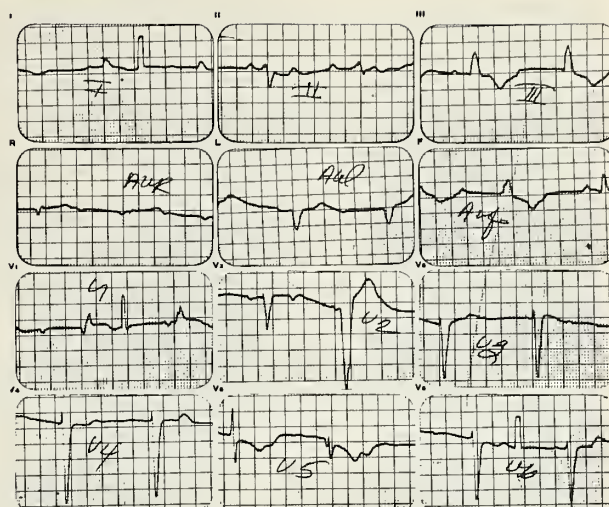


Figure 1. EKG on first admission showing complete heart block with idioventricular rhythm at 48/min.

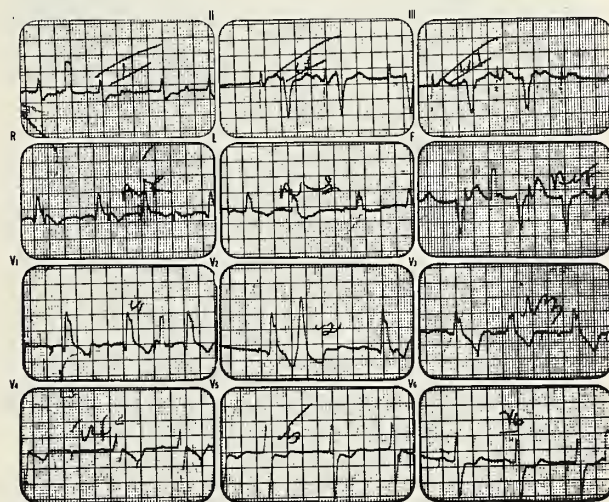


Figure 2. EKG on second admission showing sinus rhythm with right bundle branch block and left anterior hemiblock. Pacemaker artifact at 71/min without proper sensing or ventricular capture.

Palmer, *et al*⁷ described two cases of diaphragmatic contractions induced by endocardial pacemakers in 1967. In the first patient, it was related to myocardial perforation and subsequently epicardial stimulation of the phrenic nerve. In the second case, phrenic nerve stimulation was produced by prolapse of the electrode tip into the pulmonary artery and subsequent stimulation of the left phrenic nerve through its wall.

Diaphragmatic contractions have been reported with Pacemaker Twiddler's syndrome in which the pulse generator is rotated by repeated manipulation on the part of the patient. This may result in lead retraction with consequent failure of

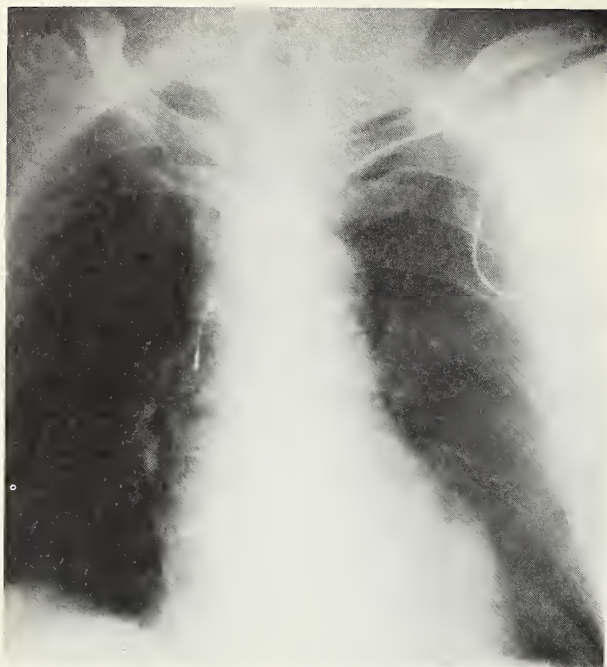


Figure 3. Chest x-ray on second admission showing lead displacement with electrode tip in the superior vena cava.

spacing action. In a case described by Bayliss, *et al*,⁸ the pacemaker electrode tip was retracted into the right subclavian vein which resulted in stimulation of the phrenic nerve and the brachial plexus. In two cases described by Meyer, *et al*,⁹ associated with diaphragmatic contractions, the tip of the electrode was displaced into the right atrium in one patient and into the left innominate vein in the other, close to the course of the right and left phrenic nerves, respectively.

In the case described here, displacement of the tip of the electrode into the superior vena cava

occurred spontaneously due to the twisting of the electrode around the pulse generator. The patient denied pulling or twisting his pacemaker, and we did not observe any signs of abnormal psychiatric behavior.

Displacement of a subendocardial pacemaker electrode is common in the first few weeks and the incidence may be as high as 12.5%.¹⁰ Later on, it remains in stable position due to fibrosis between the tip of the electrode and the endocardial surface of the right ventricle. If any patient develops diaphragmatic contractions after insertion of a permanent subendocardial pacemaker, it may be due either to myocardial perforation, or displacement of the electrode tip in the cardiac chamber, or major venous channels with subsequent stimulation of the phrenic nerve. An x-ray of the chest will be helpful in differential diagnosis. Treatment, of course, will involve repositioning of the electrode.

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Editorials

M. E. ALBERTS, M.D., Scientific Editor

HEARTS AND FLOWERS

February 14 is the feast day for three different martyrs. One of the Saints Valentine was a doctor — a Roman priest who met a tragic beheading about 269 A.D. There are two other Saints Valentine. Yet our tradition of expressing love has no connection with these saints. Customs often develop in strange and wondrous ways, frequently promoted through the years for the welfare of

merchants rather than for any particular event.

Be that as it may, Saint Valentine's Day is to be remembered. Gifts of flowers or candy and messages of sentiment and love are the order of the day. It is a good tradition even though commercialized. There is need for more days such as this day to remind us to say, "I love you."

Remember your loved one on February 14; tell him/her you truly have love in your heart. A little candy isn't too fattening — flowers are delightful — or a little silly Valentine might be fun. I love you. — M.E.A.

YEAR OF THE CHILD — 1979

The United Nations has proclaimed 1979 as the International Year of the Child. The American Academy of Pediatrics has embarked on a comprehensive action/awareness program which will reach a climax in 1980 when the 50th anniversary of the Academy will be celebrated. The Academy of Pediatrics has called their national program for promoting a renewed awareness of child welfare, "Speak Up for Children."

Four areas of child health are to be emphasized: nutrition, accident prevention, immunization and health education. The Academy, as an advocate for children, will seek to impress upon physicians, the public, parents and their children, and government officials the importance of these aspects of child welfare. Pediatricians, of course, deal in these areas in their daily practice. They possess unique training, skills and experiences in the management of infants, children and adolescents.

The role of that area of medicine will be emphasized.

It is expected many forms of promotional media will be utilized. At the annual meeting of the Academy in October, 1978, the inauguration of the "Speak Up for Children" program featured bumper stickers, T-shirts, large badges and much printed material. During 1979 all physicians who care for children can expect other forms of promotional material as well as messages for their own information or to be passed on to their patients. It is expected that drug and supply companies will join in the spirit of the program with various projects.

Children are our greatest heritage. They deserve this recognition, and the promotion of better services for their welfare. Much has been done for the welfare of children since the beginning of the Academy of Pediatrics. Much remains to be done. Many children are not recipients of the care which is their right. More and more persons will speak up for children during this, their year, 1979. — M.E.A.

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COST CONTAINMENT PROGRAM

Iowa Methodist Medical Center in Des Moines has embarked on a program to involve its medical staff in better understanding, even stabilizing or decreasing the cost of hospitalization. As is happening with medical staffs elsewhere, these physicians will be more directly exposed to the cost of hospitalization. Thus, they will become more informed of the total cost of health care.

Physicians may receive a copy of the patient's hospital bill which is a very effective way of becoming aware of the cost of inpatient care. Listings of the hospital's routine charges will be made available. Many physicians are simply not informed as to these various charges. The entire medical staff, as well as members of the house staff in training, may expect lectures or seminars on medical economics; more specifically, on cost control. Emphasis will be placed upon selectivity in ordering tests; more reliance will be put on clinical judgment instead of batteries of diagnostic procedures.

Audits will be done for various diagnoses, lengths of stay and costs of various diagnoses. Laboratory data from the physician's office should be incorporated into the hospital chart to avoid duplication of procedures. Physicians will be urged to avoid elective admission to the hospital late in the week, thus eliminating wasted weekends when many services are not available. Some

areas of medicine are on a 5-day week. The IMMC program will urge physicians to practice cost effectiveness and cost containment by curtailing office overhead wherever possible.

This initial hospital communication to the medical staff about cost containment offers suggestions directed to the physicians alone. There is no quarrel with physicians becoming involved in cost control, but what about the programs for hospitals.

Hospitals must strive to save monies; they should be involved in more strict cost containment. Centralized purchasing centers, centralized laundry facilities, and the pooling of select employee resources would save considerable money. Better utilization of the hospital facilities on weekends is always worthy of consideration. Closer cooperation through the hospital consortium could surely discover effective methods of broad cost containment. Immediate and long-range planning on the part of the hospitals, hand-in-hand with the physicians, could be effective in saving money for the patient. Surely we can do it more efficiently than by a government decree. When the government becomes greatly involved it wants first to develop a multi-million dollar administrative (dis-)organization before anything effective can be accomplished.

Other hospitals are, and all must, follow the lead of Iowa Methodist Medical Center. And IMMC must follow through with the program as outlined to provide incentives and leadership. — M.E.A.

MEDICAL MISCELLANY

ANNIVERSARY PLANNING . . . Now in process is planning for the 50th anniversary of the Iowa Medical Society Auxiliary to be observed in 1979.

DISTRIBUTE HEALTH PLAN . . . January distribution was made by the IMS of the 1978 Iowa State Health Plan of the Statewide Health Coordinating Council (SHCC). As noted by SHCC Chairman J. E. Tyrrell, M.D., the Plan is regarded as a beginning point, and is meant to be reviewed and updated on an ongoing basis. Copies of the Plan were sent to county society presidents and IMS officers.

MEDICAID MODERNIZATION . . . Implementation of the MMIS (Medicaid Management Information System) program in Iowa is intended to make claims handling more accurate and efficient. By February the State Department of Social Services expects to have new claim forms completed. Use of the forms is expected to be phased in with full usage by July. Physicians will be requested to convert from present coding to CPT-4.

CPR REQUIREMENTS . . . As of 1/1/79, the Joint Commission on Accreditation of Hospitals began requiring all medical and nursing staff involved in emergency services to have documentation of proficiency in the skills of cardiopulmonary resuscitation.

State Department of Health

WATER FLUORIDATION IN IOWA

Fluoridation is the adjustment of the fluoride level in a public water supply to maintain the optimum level for prevention of dental caries. This adjustment process includes additions of fluoride chemicals to fluoride deficient water, blending of two or more water sources with naturally occurring fluorides to maintain the optimum level, as well as defluoridation or removal of excessive levels of fluorides.

As water consumption is related to climate, optimum fluoride levels in a public water supply are determined by the annual average daily air temperatures over a 5 year period.¹ Areas such as southern Arizona which are hot and dry, a fluoride level of 0.6 to 0.7 mg/liter produces the same effect as 1.1 or 1.2 in a more northern, cool climate.

IOWA OPTIMUM LEVEL

For Iowa the optimum level has been determined to be 1.0 mg/liter for the southern portion and 1.1 for the northern. It has thus been suggested to adjust the fluoride content within the range of 1.0 to 1.2 mg/liter.

Water supplies containing 0.7 mg/liter or more natural content are considered to have dentally significant amounts of fluoride and it is generally not recommended cost-effective to adjust the fluoride level to reach 1.0 or 1.1 mg/liter. When discussing "natural" fluoridation and "controlled" fluoridation, these terms are used only to designate the process whereby the optimum fluoride level is maintained. Chemically and physiologically there is no difference between the two as the fluoride ion in the water is the active ingredient to afford protection against dental caries. The fluoride ion imparted to the water by nature is indistinguishable from that added in the water treatment plant.

The mechanism wherein the fluoride ion provides its protection to the dental enamel is a complex one. However, the basic reaction is fluoride ions replacing a portion of the hydroxyl ions in the tooth's apatite crystals to form fluorapatite.

Plaque, which is the organized bacterial colonies on the teeth, produces acids in the presence of certain foods, especially sugars. The acid thus produced, held in contact with the tooth by the plaque, initiates acid demineralization of the tooth structure.

The theory of how the fluorapatite affords protection against dental caries is that the fluorapatite is much less soluble in weak organic acids than the hydroxyapatite, making the tooth more resistant to this acid destruction.²

To obtain the maximum benefits of systemic fluorides the teeth must be exposed to fluorides at the time the enamel of the permanent teeth is being calcified. The enamel thus formed has fluoride as an integral part of its crystalline structure. Therefore, it is essential the child ingest fluoride for at least the first 8 years of life. Children introduced to fluoridated water after this age will obtain only minimal protection against dental caries.

DIFFERENCE IN DECAY LEVEL

Numerous studies here and abroad have documented without doubt both the effectiveness and the safety of water fluoridation.³⁻⁵ In general, children raised on water supplies containing optimum levels of fluoride can expect 50 to 65% less tooth decay than children raised on water supplies considered deficient in fluoride. In addition fluoridation is the most practical and economical method of providing the public partial protection against tooth decay. Current annual per capita costs to maintain the fluoridation process for a typical community nationwide are estimated to range from 8 cents for a large city to 30 cents for a

(Please turn to page 66)

STATE DEPARTMENT OF HEALTH

(Continued from page 65)

small community. With the expected reduction in dental caries through fluoridation, a cost/benefit ratio has been estimated at $\frac{1}{30}$.⁶ That is, one dollar spent on water fluoridation will return \$30 in dental treatment needs prevented. Fluoridation is indeed a bargain.

Although the benefits of water fluoridation begin occurring to a child from birth, protection against dental caries is carried throughout life. Studies indicate adults raised on optimum levels of fluoride evidence protection against dental caries well into middle age.

The early epidemiological studies on dental caries and fluorides involved cities with naturally occurring fluorides. The first trials of controlled fluoridation, which began in Grand Rapids, Michigan; Newburgh, New York; Brantford, Ontario, and Evanston, Illinois, attempted to determine whether controlled fluoridation could duplicate the dental decay preventive effects of natural fluoridation.³⁻⁵ These studies were initiated in 1945 and 1946 and were planned for 10 years. However, results after only 5 years were so convincing the U. S. Public Health Service gave its endorsement and encouraged communities to fluoridate. All four of these studies showed a 55 to 60% reduction in dental caries in children raised on fluoridated water supplies from birth.

Since that time, approximately 6,500 places throughout the United States have initiated controlled fluoridation serving over 94 million people. An additional 10.7 million people live in areas served by water supplies containing optimal levels of naturally occurring fluorides.⁷

IOWA COVERAGE

In Iowa, approximately 1,744,000 people are served by public water supplies with optimal levels of fluoride. 1,425,000 people live in communities served by controlled fluoridation and another 319,000 live in cities served by water supplies with optimum natural levels. These totals represent 86% of the population served by public water supplies.⁸ In terms of communities, 153 communities are served by public water supplies with controlled fluoridation and 177 cities with natural fluoridation.

Nationally, Iowa ranks 14th with 62% of total state population using fluoridated water.⁷ Ap-

proximately 28% of Iowans live in areas inaccessible to public water supplies. While 86% of the population in Iowa served by public water supplies are drinking water with optimum levels of fluoride, there are 436 communities with a total population of 294,000 without this proven public health measure. A breakdown of these 436 cities reveals 358 of less than 1,000 population; 69 between 1,000 and 3,000; 6 over 3,000 but less than 5,000; and 3 between 5,000 and 6,000. All cities over 6,000 population are fluoridated or have natural fluoridation.

GRANT PROGRAM

To encourage cities to fluoridate and assist them with the implementation cost, the Dental Health Section of the Iowa State Department of Health administers the Fluoridation Grant Program. This grant program matches local funds on a dollar-for-dollar basis up to a maximum of \$1,500 to reimburse a city their cost of installing fluoridation equipment. To be eligible the city must be served by a public water supply containing less than 0.7 mg fluoride/liter and have a population under 5,000. Currently 433 communities are eligible for this program.

At present, costs to implement fluoridation in these cities is estimated at \$3,000 for a typical community. A per capita annual cost to maintain fluoridation would be approximately 30 cents.

Many reasons exist to explain the less than universal acceptance of fluoridation. However, economics certainly is involved, especially in very small communities where amortization of capital costs must be borne by a relatively small number of taxpayers. Ongoing operational and maintenance expenses are also proportionally larger for small communities. Other reasons that can be cited are arguments from those who view fluoridation as an infringement of individual freedom. Public apathy is certainly involved. While dental caries is the most prevalent chronic disease of childhood, it is rarely a life threatening disease.

Fluoridation is considered an almost ideal public health measure as the individual needs take no special action on his part to derive the benefits of the measure. Fluoridation is no longer a controversial subject in the scientific arena and is considered the most effective, efficient, practical, and safe method available for the prevention of dental caries today.

REFERENCES

The references noted in this paper are available either from the State Department of Health or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

GENETIC COUNSELING CLINICS

Clinics in 15 Iowa communities will be conducted between February and June by the Regional Genetic Consultation Service. The RGCS is a dimension of the Birth Defects Institute of the Iowa State Department of Health.

The following tentative schedule has been reported (date shown after the community):

February: Dubuque (7), Ft. Dodge (7), Ames (8), Davenport (12); March: Cedar Rapids (2), Ottumwa (6), Burlington (14), Des Moines (21/22), Mason City (21), Waterloo (22), Creston (29); April: Carroll (10), Council Bluffs (11), Davenport (16), Dubuque (25), Des Moines (30); May: Fort Dodge (16), Ames (17), Sioux City (24), Spencer (25), Creston (30), Des

Moines (31); June: Cedar Rapids (8), Mason City (20), Waterloo (21).

The clinics are available to any individual with a birth defect or genetic disease, or parents of an affected child, or anyone who is concerned about the risk of having a child with a genetic disease. Referrals by physicians are welcomed.

Inquiries or appointments can be made by contacting the regional consultant most convenient: Central (515/283-6282); Northwest (515/955-5265); Northeast (319/398-7733); Southwest (515/283-6907); Southeast (319/353-5336). Counseling is provided by RGCS team members, including a medical geneticist from the University of Iowa. The service is available at no charge to Iowans.

December 1978 Morbidity Report

Disease	Dec. 1978 Total	1978 to Date	1977 to Date	Most Dec. Cases Reported From These Counties
Amebiasis	4	162	104	Dallas, Baane
Brucellosis	1	18	25	Dubuque
Chickenpox	776	7144	8223	Scattered
Encephalitis, viral	8	37	13	Allamakee
Giardiasis	3	39	42	Boone, Montgomery
Hepatitis, A	11	143	118	Scattered
Hepatitis, B	9	96	101	Scott, Palk, Linn, Boone, Buchanan
type unspecified	3	60	37	Sac, Marshall, Jahnsan
Herpes simplex	4	93	114	Jahnsan
Infectious mononucleosis	69	1109	1122	Scattered
Meningitis aseptic	6	39	24	Delaware, Boone, Polk, Ringgold Winneshiek
bacterial	17	91	148	Scattered
Mumps	19	192	1359	Scattered
Pertussis	0	3	4	NA
Pneumonia	51	2390	1344	Scattered
Rabies in animals	18	142	136	Scattered

Disease	Dec. 1978 Total	1978 to Date	1977 to Date	Most Dec. Cases Reported From These Counties
Rubella (German measles)	7	68	179	Scattered
Rubeola (measles)	15	72	76	Scattered
Salmonella	37	213	293	Scattered
Shigella	22	85	81	Scattered
Tuberculosis total ill	8	103	93	Palk, Des Moines, Linn, Tama, Wadbury
bact. pas.	8	79	78	Same as above
Venereal diseases:				
Gonorrhea	503	5579	6106	Scattered
P. & S. Syphilis	1	38	43	Scattered

Labaratory Virus Diagnosis Without Specified Clinical Syndrome: Eaton's agent — 19, scattered; Legionnaires Disease — 1 each, Tama and Marshall; ECHO virus Type 4 — 1 each, Scott and Baane (both serology); ECHO virus Type 2 — 1, Winneshiek (isolated); ECHO virus Type 11 — 1 each, Jahnsan and Winneshiek (both serology); Psittacosis — 1, Tama; Cytomegalavirus — 1, Johnson (isolated); Guillain-Barre — 1, Scott; Reye Syndrome — 1, Wapella.

About IOWA Physicians

Dr. Dallas O. Minchin, Council Bluffs, has been appointed by Governor Robert Ray to a one-year term on Iowa Commission on Substance Abuse.

... **Dr. Robert C. Larimer**, Sioux City, was named president of the Western Conference of Medical Service Plans, an organization representing 47 Blue Shield plans, at a recent meeting of the group in Portland, Oregon. Dr. Larimer joined the Blue Shield of Iowa Board of Directors in 1961 and has served as vice president, second vice chairman, and as a member of the Subscriber Relations and Medical Advisory Committees. He also serves on the Board of Directors of Blue Cross of Western Iowa and South Dakota.

Dr. William J. McMillan, Ottumwa, has been named a diplomate of the American Board of Otolaryngology. ... **Dr. Robert Eaton**, Clarion, was elected recently to the West Central Iowa Subarea Advisory Council of the Iowa Health Systems Agency. Dr. Eaton will represent physicians in Wright County. ... **Dr. Dwight Mater**, Knoxville physician for more than 40 years, retired November 1. Dr. Mater received the M.D. degree at U. of I. College of Medicine and interned in San Francisco. He plans to make Knoxville his permanent residence but will spend his winters in the South. ... **Dr. Michael J. Versackas**, Des Moines, has been named a diplomate of the American Board of Ophthalmology and a fellow of the American Academy of Ophthalmology. ... **Dr. J. W. Reinertson** is new medical staff president at St. Luke's Hospital in Cedar Rapids. Other officers are — **Dr. William E. Kettelkamp**, vice president and **Dr. Kingsley B. Grant**, secretary-treasurer. All are Cedar Rapids physicians. ... **Dr. Kiyoshi Furumoto** and his wife, Alice, were honored recently as Keosauqua's outstanding citizens for 1978. Dr. Furumoto was cited for his work in providing

medical care, and his wife was recognized for her active role in arts activities.

Dr. Barry S. Barudin began private pediatric practice in Davenport in January. Dr. Barudin received the M.D. degree from Chicago Medical School; interned and completed his residency at University of Michigan in Ann Arbor. Dr. Barudin is current director of the Children and Youth Project at the Community Health Care Center in Davenport. He is also co-director of the perinatal program at St. Luke's Hospital. ... **Dr. Thomas J. McIntosh** has been named president of the medical staff at Mercy Hospital in Cedar Rapids. Also elected were — **Dr. John J. Jacobs**, president-elect; and **Dr. Larry Strathman**, secretary-treasurer. All are Cedar Rapids physicians. ... New officers of Clinton County Medical Society are **Dr. Surendra Kumar**, president; **Dr. Charlton Barnes**, vice president; and **Dr. James Ives**, secretary-treasurer. Delegates are **Dr. G. T. Schmunk** and **Dr. G. L. York**. ... The Floyd Valley Hospital medical staff in LeMars recently elected **Dr. James Powell**, president; **Dr. Gerald Van Es**, vice president; and **Dr. Glenn Van Roekel**, secretary. All are LeMars physicians. ... **Dr. Charles J. LaTendreese** has opened a general medical and surgical practice in Grundy Center. A native of Eveleth, Minnesota, Dr. LaTendreese received the M.D. degree at the University of Minnesota; interned at the University of Kentucky Medical Center; and completed his surgery residency at Deaconess Hospital in St. Louis, Missouri.

Dr. J. L. Ptacek, Webster City physician for 33 years, retired January 1. Dr. Ptacek received the M.D. degree at Western Reserve University Medical School in Cleveland, Ohio; interned and completed his residency at Westchester County

Hospital in New York. Prior to locating in Webster City, Dr. Ptacek practiced in Council Grove, Kansas. . . . At a recent meeting of the Pottawattamie-Mills County Medical Society, Dr. Ralph Hopp was named president; Dr. Lloyd Smith, president-elect; Dr. Arthur Sciortino, vice president; and Dr. Thomas Pester, secretary-treasurer. All are Council Bluffs physicians. At Mercy Hospital in Des Moines, the medical staff elected Dr. Frederick Katzmann, president; Dr. Robert Jones, president-elect; and Dr. Ala Daghestani, secretary-treasurer.

DEATHS

Dr. Kenneth E. Goebel, 50, Council Bluffs, died January 1. Dr. Goebel received the M.D. degree and completed his residency in obstetrics and gynecology at Creighton University School of Medicine. He was a member of the Iowa Clinical Surgical Society and the American Board of Obstetrics and Gynecology.

Dr. Donald K. Bengé, 58, Hampton, died December 29. Dr. Bengé received the M.D. degree at U. of I. College of Medicine. Prior to locating in Hampton, he practiced in Dows, Iowa.

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Medical Assistants



by **BETTY EHLERT, CMA-A**

STATE CONVENTION — APRIL

The 1979 meeting of the American Association of Medical Assistants, Iowa State Society, Inc., is scheduled April 20, 21 and 22 at the Merle Hay Travelodge in Des Moines. The April issue of the *IMS JOURNAL* will contain program and registration details.

NATIONAL CONVENTION

Twelve medical assistants from Iowa attended the 22nd annual national convention of the American Association of Medical Assistants in Boston October 23-28.

A wide range of educational presentations (covering both administrative and clinical topics) were offered. Major speakers included Hoyt Gardner, M.D., Louisville, Kentucky, president-elect of

the American Medical Association.

Iowa's Jeanne D. Green, CMA, who served ably as AAMA national president in 1977-78, passed the gavel to Wini A. Schwartz, CMA-AC, Los Angeles, at the inaugural banquet. James F. Bishop, M.D., Jeanne's physician employer, was the banquet master of ceremonies.

1978-79 AAMA officers are Wini A. Schwartz, CMA-AC, California, president; Dorothy Sellars, CMA-A, Virginia, vice-president; Jean Mobley, CMA-AC, Texas, president-elect; Dorothy Har- tel, CMA-A, Maryland, secretary-treasurer; Betty Mays, CMA-A, Arizona, speaker of the house; Rita Paris, RT, CMA-AC, Texas, vice-speaker.

The 1979 annual national meeting will be in New Orleans.

The pictures below were taken at the national convention.



NATIONAL SCENES — Upper left, Susan S. Cray, left, editor, Professional Medical Assistant, receives meritorious service award from President Jeanne Green, Davenport. Upper middle, Banquet dignitaries include, from left, incoming president, Wini Schwartz; J. F. Bishop, M.D., Davenport, master of ceremonies, and Jeanne Green, retiring national president. Lower left, from left, Jean Gald, Iowa AAMA president, Davenport; Margaret Parter, Iowa immediate past president, Cedar Rapids, and Janet Hensinger, CMA, Kentucky. Lower right, Hoyt Gardner, M.D., AMA president-elect, Louisville, Kentucky, left, and AAMA President Green, Davenport.

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PSYCHIATRIC RESIDENCY — Immediate vacancies for PG2 through PG4 through July 1, 1979. Those eligible for an Iowa resident's license via ECFMG receive stipends of: 1st year, \$21,294; 2nd year, \$22,360; 3rd year, \$23,478. Those eligible for a regular Iowa license via FLEX or reciprocity receive stipends of: 1st year, \$23,478; 2nd year, \$24,648; 3rd year, \$25,896. Write T. B. McManus, M.D., Superintendent, Mental Health Institute, Cherokee, Iowa 51012 or call collect 712/225-2594. Equal Opportunity Employer.

NEBRASKA — New Hospital Emergency Department ready to expand to full time coverage. Hours, Monday-Friday. No Weekends. Two physicians needed for week day/night Emergency Department coverage. Excellent Income plus Benefits. Write No. 1533, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

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RADIOLOGIST — Immediate opening for board certified or eligible radiologist in JCAH approved 301 bed hospital with a progressive radiology department including special procedures and ultrasound. Excellent technical and secretarial staff. Many fringe benefits including sick leave, vacation, life and health insurance, retirement program and continuing medical education opportunities. Contact Personnel Service, Veterans Administration Medical Center, 30th and Euclid, Des Moines, Iowa for information. (515) 255-2173 ext. 345. The VA is an Equal Opportunity Employer.

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DIRECTOR WANTED — Accredited Family Practice Residency, University affiliated. Board certification in F.P. and experience in F.P. residency desirable. Interested candidates should direct inquiries, credentials and curriculum vitae to Arnold T. Nielsen, M.D., Director of Medical Education, Iowa Lutheran Hospital, University at Penn Avenues, Des Moines, Iowa 50316.

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PHARMACIST — Seeking professional clinic in which to locate. Have Masters Degree in Hospital Pharmacy. For additional information, please write No. 1532, Journal of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265.

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NO HURRY FOR NATIONAL HEALTH INSURANCE

THE LONG AND ENDURING question of national health insurance was placed before a sample of our state's population recently by the Iowa Poll.* The findings were published in the DES MOINES SUNDAY REGISTER on January 14, 1979.

Interestingly, the split between those Iowans *for* and those *against* national health insurance was almost equal. Forty-two per cent of the respondents supported a government health program to cover all citizens. Forty-three per cent said they would leave the present system unchanged. And the balance (15%) were undecided.

Gathering and publishing public opinion is an exercise most everyone finds interesting, and sometimes useful to support a point of view. Pollsters usually try hard to pose inquiries free of bias. They use special techniques so the opinions of a small sample will reflect the total population.

Measuring public sentiment in this way can be somewhat risky. (At least those defeated political candidates who have led in the polls would say so.) Any poll must be a bit uncertain with an issue so complex as national health insurance. To answer a simple *for* or *against* question is asking a lot. It's expecting a lot even to assume that many citizens have a very thorough understanding of what broad ramifications might be embodied in an NHI program.

It would be interesting to poll a selected audience on NHI, then give those involved equal exposure to an expert commentator on both sides of the issue, followed by a re-poll.

The debate on national health insurance has stretched over several decades. There has been opportunity for analysis, for comparison and for evaluation of the potential impact on society. The thrust and scope of NHI proposals have changed as time has passed. Recently (in December, 1978), the House of Delegates of the American Medical Association altered its stand on NHI. Instead of presenting a bill draft in 1979 (as has been the case for several years) and seeking legislative support for it, the AMA will proceed differ-

ently. A majority of the 260 or so physician policy-makers in the AMA House have said legislation should be introduced *only if necessary* and with the following principles:

"Resolved, that the AMA recommend to the Congress of the United States modifications to our present health care system embodying the following principles:

"1. Requiring minimum standards of adequate benefits in all health insurance policies sold in the U. S. with appropriate deductible and co-insurance.

"2. A simple system of uniform benefits provided by the federal, state and local governments for those individuals who are unfortunate enough (through no fault of their own, i.e., age, disability, financial hardship, etc.) not to be able to provide for their own medical care.

"3. A nationwide program by the private insurance industry of America (and government if necessary for reinsurance) to make available catastrophic insurance coverage for those illnesses and individuals where the economic impact of a catastrophic illness could be tragic. All catastrophic coverage should have an appropriate deductible and co-insurance to make it economically feasible and to avoid abuse.

"4. A program developed pursuant to those principles should be administered at the state level with national standardization through federal guidelines."

It would appear these principles are appropriate in our economic times. They look out for the less fortunate. They encompass catastrophic situations. They place responsibility with the private sector, allowing for state supervision pursuant to federal guidelines.

In the days ahead, federal lawmakers face a stiff challenge to provide a variety of programs within a restricted economy. The prospect of a further national deficit appears likely. The imposition of a broad national health insurance, such as some advocate, would add to our economic chaos.

Based on findings of the Iowa Poll, cited earlier, there is no mandate in this state for NHI.

* The Iowa Poll is a copyrighted program of the Des Moines Register and Tribune Company.

Presidential Invitation To Call Questions



On Monday, March 26, I plan to be at Iowa Medical Society Headquarters in West Des Moines. I expect to be available particularly between 2 and 4 p.m. that day.

If you have a question or a comment, please make a note to call me during this period. We have a toll free number for member use; it's 1/800-422-3070.

We'll try to respond to any questions about the IMS, its programs and officers; about Blue Shield; about the Iowa Foundation for Medical Care and peer review; about the Iowa Health Systems Agency and health planning — or any other topic applicable to medicine in Iowa. If we don't have the answer or the information desired, we'll do our best to get it for you.

You might want to know about the new continuing medical education requirements. We can try to amplify on the material sent out by the Society in February.

There never seems to be a shortage of

problems. We now have a question on the equity of a reimbursement differential under Medicare/Medicaid for head and body scans. The allowance for scans on patients in the hospital owning the equipment is substantially more than for patients sent in from another hospital in the area. Why? We expect to look into the matter.

Maybe you have observed another kind of inequity. If so, think about calling me March 26. If there's any response to this call-in idea maybe we can repeat it occasionally.



Russell S. Gerard, M.D.

Iowa Medical Society

VOL. 69, No. 3

MARCH 1979

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MAC REGULATIONS/THE PHYSICIAN AND PHARMACIST

The federal Maximum Allowable Cost (MAC) program has complexities worthy of note and understanding by Iowa physicians. The Iowa pharmacist is reimbursed for medications dispensed to Medicaid patients in accordance with MAC regulations and pursuant to physician instructions.

When a physician states on a prescription *dispense as written* the pharmacist must provide that specific drug with no substitution permitted. If the drug has a generic equivalent on the MAC list the pharmacist can be reimbursed only at the federally-established cost level. Any substitution by the pharmacist is a violation of the law. He must absorb the economic loss when such occurs.

However, if the physician states, along with the DAW reference, the phrase *medically necessary* then the pharmacist may bill for the actual cost of the medication prescribed by the physician.

The Iowa Pharmacists Association has submitted two possibilities for consideration by IMS members: (1) When a physician writes a prescription for drugs for Medicaid patients specified under MAC regulations, allow the pharmacist to make the product selection where there are no contraindications, or (2) In instances where the physician's professional judgment dictates that a particular brand be dispensed, place the phrase *medically necessary* on the prescription.

For your information, these drugs are under federal MAC regulation and are applicable to Medicaid:

Drug Name, Strength and Dosage Form	MAC Cost/Unit
Ampicillin Capsule 250 mg	\$0.0725/cap
Ampicillin Capsule 500 mg	\$0.1390/cap
Ampicillin Suspension 125 mg/5 ml (100 ml)	\$0.0145/ml
Ampicillin Suspension 250 mg/5 ml (100 ml)	\$0.0205/ml
Penicillin VK Tablets 250 mg	\$0.0535/tab
Penicillin VK Tablets 500 mg	\$0.1025/tab
Penicillin VK Suspension 125 mg/5 ml (100 ml)	\$0.0120/ml
Penicillin VK Suspension 250 mg/5 ml (100 ml)	\$0.0160/ml
Tetracycline HCL Capsule 250 mg	\$0.0250/cap
Tetracycline HCL Capsule 500 mg	\$0.0465/cap
Propoxyphene HCL Capsule-65	\$0.0317/cap
Propoxyphene HCL with APC-65	\$0.0330/cap
Chlordiazepoxide HCL Capsules 5 mg	\$0.0270/cap
Chlordiazepoxide HCL Capsules 10 mg	\$0.0378/cap
Chlordiazepoxide HCL Capsules 25 mg	\$0.0640/cap

IOWA Medical Miscellany

NOMINATING COMMITTEE . . . The 1979 IMS Nominating Committee will be Sunday, April 1, at Society Headquarters in West Des Moines. Members of the NC are physician representatives selected at the district caucuses. The slate of candidates compiled by the NC will be acted on by the House of Delegates April 22. IMS 1979-80 offices to be filled include president-elect, one trustee, vice-president, one AMA delegate and one alternate, the speaker and vice-speaker of the House, plus four district councilors.

HEALTH PLANNING CONFAB . . . The IMS will offer an afternoon program on health planning March 22 at Society Headquarters for interested physicians. Gary Schwartz, director of the AMA Department on Community Health Systems, will discuss national developments. In addition, state updates will be offered on the HSA's, the SHPDA and the SHCC. The importance of physician involvement will be reviewed. More information is available on request.

HMO CONFERENCE . . . Health Maintenance Organizations: Exploring Alternative Delivery Models is the title of a one-day conference set for March 30 at the Hotel Fort Des Moines. The session, which includes the IMS as a co-sponsor, will be open to individuals from business, industry, labor, health provider groups and consumers. More information is available from IMS Headquarters.

MENTAL HEALTH MATTERS . . . At a February meeting the IMS Committee on Psychiatric Care, among other things, (a) considered developments associated with the possible reorganization of state mental health administration (the committee has generally supported the existing dispersed arrangement), and (b) discussed (and opposed) direct reimbursement to psychologists for Medicaid services.

HANDBOOK DISTRIBUTION . . . The 1979 Handbook for the House of Delegates will be distributed in late March. The Handbook contains committee reports and other material for delegate review in advance of the April meeting.

DEALING WITH PREGNANCY . . . A May 7/8 conference for individuals working with adolescent pregnancies and teenage parents is planned for Des Moines at the Hyatt House. Speakers include Elizabeth K. Jerome, M.D., medical director, Teen-Age Medical Services, Minneapolis Children's Health Center, and Ezra C. Davidson, Jr., M.D., professor and chairman, Department of Obstetrics and Gynecology, Martin Luther King, Jr. General Hospital, Los Angeles. The conference is co-sponsored by the March of Dimes (Central Iowa Chapter), Iowa State Department of Health and Scanlon Medical Foundation/IMS.

PRACTICE MANAGEMENT . . . A workshop for established physicians on how to manage a medical practice is set for Wednesday, March 28 at IMS Headquarters. The program will cover patient relations, financial systems, personnel, medical records, facilities and legal considerations. Contact Society Headquarters for registration info.

SCANLON MEETING . . . The annual meeting of the Scanlon Medical Foundation/Iowa Medical Society will occur March 22 at IMS Headquarters. The SMF/IMS will receive a report on audit activities of the medical student loan program.

NATIONAL VP . . . Richard M. Freeman, M.D., professor, Department of Medicine, University of Iowa, has been elected vice president of the National Kidney Foundation. Dr. Freeman was one of the founders of the Kidney Foundation of Iowa in 1969. He was the KFI president from 1974 to 1976.

Accept no substitute for your professional judgment

As a physician, you have the right to prescribe the drug which you believe will most benefit your patients. Now, substitution laws make it more difficult to exercise that right. In many states, unless you specifically direct pharmacists to dispense your brand-name prescription as written, they may be required by law to substitute another drug for your brand-name prescription.

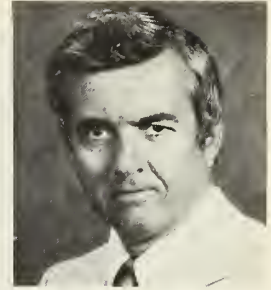
This means that the ultimate drug selection is no longer yours; its source is left to the pharmacist's discretion. You will have forfeited your right to prescribe as you see fit. Preserve your rights. Specify that you will accept no substitution.

When you accept no substitutes...

- You ensure that your patient receives exactly that product you have specified on your prescription
- You choose the quality of the product dispensed to your patient
- You can exercise the right to select a product based upon its proven therapeutic performance and to select a manufacturer that stands behind its brand name or generic product
- You can support the kinds of research programs that are vital to new drug discovery and development
- You can help sustain important physician, pharmacist and patient education services supported by innovative, research-oriented firms

For complete information on the drug substitution law effective in your state, please consult your local Pfizer Representative.

The Question Box



by JAMES D. COLLINS, M.D.

1979 SCIENTIFIC SESSION

James D. Collins, M.D., is chairman of the 1979 IMS Scientific Program. He comments here on the 1979 program which is scheduled June 18-21 at Tan-Tar-A in Missouri.

Why should IMS members attend the 1979 Scientific Session?

The quality of the speakers, the breadth of the program, and the excellent facilities are the three main reasons. Those physicians who attend will get an update on important medical matters, such as use of antibiotics, Legionnaire's disease, coronary by-pass surgery, etc. We'll also take a look at some of the more peripheral areas of medicine, e.g., aircraft accident investigation, comments by a pathologist who investigated the Tenerife disaster, infection control, etc. Federal legislation relating to medicine will be highlighted by an AMA Washington staff member. The program contains much useful and diversified information to be presented by highly qualified individuals.

How would you characterize this year's program?

I am excited about it because it offers much for all medical disciplines. I know several of the speakers personally. They are excellent in manner of delivery and they are expert in their fields. The entertainment is worth the meeting, and I refer to the "Singing Doctors" from Springfield, Mo. This group makes numerous public appearances and has several records available. They are one of the outstanding musical groups in the midwest.

We are in the required CME era. Will the IMS session help meet the new licensure renewal requirements?

As you know, Iowa licensed physicians must have 20 hours of Category I CME before June 1, 1980. The program at Tan-Tar-A has been approved for 11.5 hours of Category I credit. You will be able to obtain over half the hours needed for 1979 plus provide for yourself and your family the opportunity for a pleasant vacation.

What about the setting, e.g., facilities, convenience, etc.?

The Tan-Tar-A Resort is one of the outstanding recreational facilities in the midwest. It is on beautiful Lake of the Ozarks which offers numerous leisure activities. There is a golf course, plus tennis courts, bowling alleys, swimming and many other recreational opportunities. I have visited Tan-Tar-A several times with my family and have found it a delightful vacation location.

CONTINUING EDUCATION COURSES & CONFERENCES

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

March 22	Radiation Therapy Seminar	April 5-6	Iowa Perinatal Meeting, Des Moines
April 2-6	Intensive Course in Pediatric Nutrition	April 20	Otolaryngology Clinical Conference
April 4	Ophthalmology Clinical Conference	April 26	Radiation Therapy Seminar

MEDICAL MISCELLANY

LEGISLATIVE DEVELOPMENTS . . . As this is prepared, health related matters have received only limited attention by the Iowa General Assembly. Most pressing of the issues has been the bill to allow optometrists to use certain topical agents for diagnostic purposes. The IMS has exerted significant effort to convince lawmakers this measure is unwise.

OTHER BILLS . . . Various other medically related bills have been introduced, but they have not progressed to date. Included here are measures to license occupational therapists, to deal with generic substitution, to restrict use of amphetamines except for two disorders, to legalize manufacture and sale of laetrile, etc.

SAFE TRANSPORTATION . . . The IMS Committee on Safe Transportation met February 14 with representatives of the Departments of Transportation and Public Safety to discuss, among other things, the use of various safety restraints in motor vehicles.

TERM INSURANCE PROGRAM . . . Enrollment remains open for the new IMS life insurance program. In this initial enrollment period applicants may obtain one unit of coverage regardless of insurability. Two mailings have been made on the program. Further information is available from IMS Headquarters.

CME FOLDER . . . A Q&A folder on continuing medical education requirements for physicians and surgeons licensed in Iowa was mailed recently to IMS members. The brochure attempts to provide concise information on the new CME activity required for licensure renewal.

HERMAN SMITH DAY . . . The third annual Herman J. Smith, M.D., Day will be April 18 at Iowa Lutheran Hospital in Des Moines. Tentative presentations are scheduled by Charles Read, M.D., University of Iowa (Family Treatment of Diabetes), Dan Anzia, M.D., Loyola University (Sexuality and Medical Practice), and D. K. Granner, M.D., University of Iowa (Hypoglycemia). The afternoon program is a project of the ILH medical staff and the Family Practice Residency Program.

Librax®

Each capsule contains 5 mg
chlordiazepoxide HCl and 2.5 mg clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows:

"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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The "Pigeon-Toed" Child

G. S. BASSETT, M.D., and
M. R. MICKELSON, M.D.
Iowa City

Parent concern over toeing-in in an otherwise normal child is often great. The authors call for a systematic physical examination, a proper diagnosis, appropriate treatment and reassurance to benefit both parent and child.

ONE OF THE more common problems faced by the primary care physician is the child who toes-in. Parents often express concern. Their child has neither a history of pain nor a limp to lead the physician to consider other more serious diagnoses, but an in-toeing condition is present.

A thorough pediatric history and physical examination should be performed to exclude neuromuscular causes such as spastic cerebral palsy. Once assured the child is otherwise healthy, most in-toeing can be attributed to three distinct causes. These are the result of structural changes occurring either singly or in combination at the level of the femur, the tibia, or the foot. A proper understanding of the pathomechanics in-

involved coupled with a systemic approach to physical examination will lead to the appropriate diagnosis and, hence, a rational form of therapy.

FEMORAL ANTEVERSION AS A CAUSE OF IN-TOEING

The femoral neck unites with the shaft of the femur at an angle of about 130 degrees in the coronal (frontal) plane. In the sagittal plane, the femoral neck is found to be inclined forward with respect to the axis of the femoral condyles 10-15 degrees in adults (Figure 1). This forward twisting of the femoral head and neck with respect to the femur is termed "anteversion." Increased anteversion results in excessive internal rotation of the lower limb during gait and thus "toeing-in."

Using roentgenographic techniques, the degree of femoral anteversion for all age groups of normal children has been determined. Shands and Steele⁸ obtained average values of 39 degrees for the first year, diminishing 8 degrees the second year, with further decreases in femoral anteversion by approximately 1 degree per year until the normal adult range of 15 degrees was reached. Fabry¹ performed similar studies in 175 children with a toeing-in gait pattern. The toeing-in group had an average of 42 degrees of anteversion versus 24 degrees in normal controls.

That bone will remodel to conform to the stresses placed upon it is a well known fact (Wolff's Law). In addition, the rate of epiphyseal growth is very sensitive to pressure (Hueter-Volkman

The authors are associated with the Department of Orthopaedic Surgery, University of Iowa Hospitals and Clinics, Iowa City, Iowa 52240.

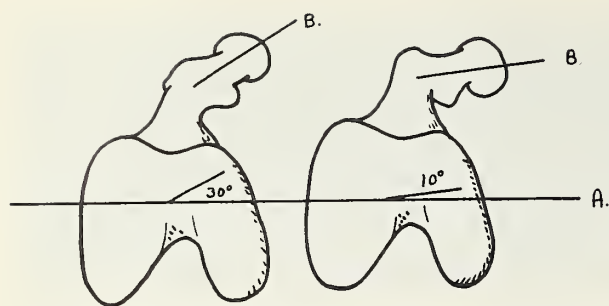


Figure 1. The diagram on the left shows increased femoral anteversion; the femoral neck (B) is inclined 30 degrees with respect to the condyles (A). The diagram on the right represents normal femoral anteversion.



Figure 2. Reverse tailor position.

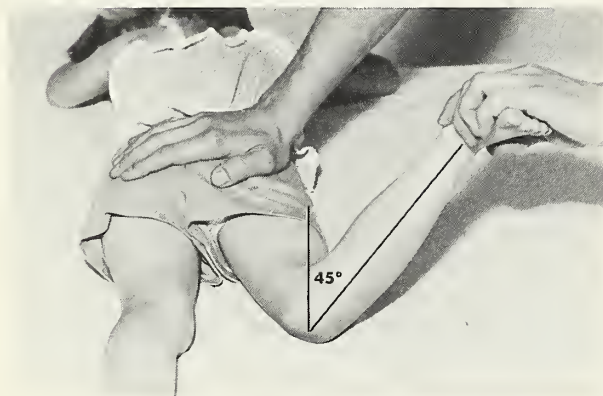


Figure 3. Internal rotation of the hip — 45 degrees.

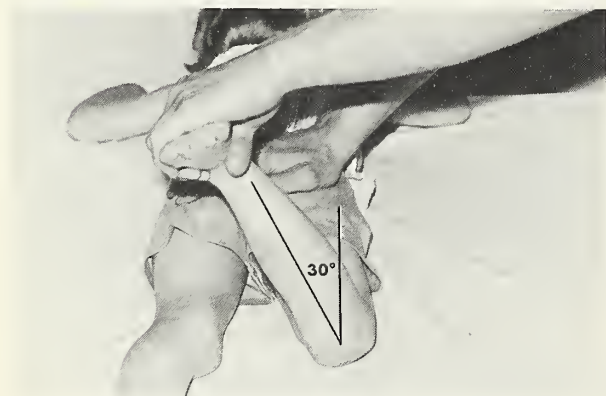


Figure 4. External rotation of the hip — 30 degrees.

Law). Prolonged posturing habits of children are known to alter the torsional patterns of development in the lower extremities. Any sleeping or sitting position with the hip in internal rotation will increase femoral anteversion. Specifically, the reverse tailor position is associated with increased femoral anteversion (Figure 2).⁵

Clinically, excessive femoral anteversion exists if internal rotation of the hips (Figure 3) exceeds the degree of external rotation (Figure 4). The examination is performed with the child prone and the knees flexed to 90 degrees. In normal children external rotation of the hips exceeds internal rotation until the age of two or three years, and is essentially equal thereafter.⁶ Additionally, when the child is standing in an in-toed position, the patellae will be pointing medially (Figure 5).

Treatment of in-toeing secondary to increased femoral anteversion is directed at removing any deforming postures, such as the prone knee-chest or reverse tailor positions. The child is encouraged to sit Indian-style so as to place the hips in external rotation. The parents should be reassured this "increased twisting of bone" is a normal finding and is present in large numbers of children. As femoral anteversion decreases with age and/or external tibial compensation occurs, the tendency to toe-in will diminish. Bracing consisting of twister cables or Denis Browne splints has not been shown to be effective. In his follow-up study, Fabry¹ found only a 2-3 degree total improvement of femoral anteversion in a group treated with twister cables and/or Denis Browne splints over an untreated group. Furthermore, the use of a Denis Browne splint is associated with increased valgus deformity in the hindfoot and, hence, should not be used. Surgical intervention, i.e., subtrochanteric derotational osteotomy, is indicated only in extremely severe cases of cosmetic or functional deformity. Hence, surgery is rarely performed and only after completion of skeletal growth.

INTERNAL TIBIAL TORSION AS A CAUSE OF IN-TOEING

In the normal adult, the plane of motion of the ankle lies external to that of the knee. Hence, the feet turn outward slightly with respect to the knee. This difference in orientation of the knee and ankle is achieved by twisting of the tibia externally about its long axis, as manifest by the medial malleolus lying anterior to the lateral malleolus in the coronal plane.

The "normal" degree of tibial torsion for various



Figure 5



Figure 6

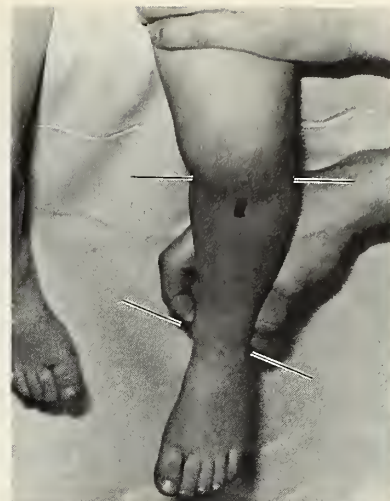


Figure 7

Figure 5. In-toeing secondary to increased femoral anteversion. Figure 6. Position frequently associated with internal tibial torsion and metatarsus adductus. Figure 7. Internal tibial torsion.

age groups has been determined by several investigators. Khormosh³ studied a large group of normal children and found that newborns had a mean of 2.2 degrees of external tibial torsion. The external torsional angle of the tibia increased slowly with normal development. In the normal adult tibia, the average degree of external torsion was 20-23 degrees.²

The exact cause of persistent internal tibial torsion is not known. One might expect that medial rotation of the fetal limb and the in utero position would play a significant role. However, the degree of torsion noted at birth, whether internal or external, is minimal. Hereditary and nonhereditary forms are known to occur. The latter is much more common and appears to be related to posturing habits of children. Sleeping in the prone knee-chest position or sitting with the feet internally rotated beneath the buttocks (Figure 6) have been shown to be associated with persistent internal tibial torsion.⁵ In accordance with Wolff's Law, persistent rotatory stresses acting on the tibia may, with time, inhibit the usual increase in external torsion.

Clinically, the presence of internal tibial torsion may be assessed by inspection and palpation of the leg. The child is examined in the sitting position (knees flexed 90 degrees). With reference to the axis of the knee, the medial and lateral malleoli are palpated with the thumb and index finger. Internal tibial torsion exists if the medial malleolus lies posterior to, or in the same plane as

the lateral malleolus with reference to the axis of the knee (Figure 7).

The principles of treatment are very similar to those emphasized in femoral anteversion. Certainly, any deforming forces should be diminished or reversed. Hence, infants are placed on their sides while sleeping and children are discouraged from sitting on their feet. The parents should once again be reassured this "twisting" of the tibia will usually resolve spontaneously. Only if there is a strongly positive family history for internal torsion deformity in grandparents, parents, or skeletal mature siblings, should such optimism be tempered. Denis Browne splints or twister cables are ordinarily not advised for the reasons stated previously. Surgical correction, i.e., derotational tibial osteotomy, is rarely performed.

METATARSUS ADDUCTUS AS A CAUSE OF IN-TOEING

The third common cause of in-toeing is congenital metatarsus adductus, also termed metatarsus varus by some authors. This is a deformity with clinically obvious abnormalities occurring in the anterior portion of the foot (Figure 8). The metatarsals are adducted and occasionally inverted (varus) upon the tarsometatarsal joint. The great toe is frequently adducted to a greater degree, leaving a space between the first and second toes. Hence, a straight line drawn through the center of the heel falls lateral to the second metatarsal rather than through it as in normals. As a result of the adduction, the lateral border of the



Figure 8. Metatarsus adductus.

foot is convex rather than concave and the base of the fifth metatarsal may be prominent. The heel may be in valgus. The Achilles tendon is not tight and this serves to easily differentiate the metatarsus adductus deformity from clubfoot.

The etiology of metatarsus adductus is uncertain. Kite⁴ noted that the peroneal muscles are weaker. He postulates that the anterior and posterior tibialis muscles are deforming forces contributing to the abnormality. Whether this muscle imbalance is primary or secondary is not known. Posturing habits, such as sleeping in the prone knee-chest position or sitting with the feet internally rotated beneath the buttocks, are associated with forefoot adduction deformities.⁵

DIAGNOSIS

The diagnosis is made on the basis of the features noted previously. Associated internal tibial torsion is present frequently and should be sought as described earlier. Before proper treatment is instituted, a determination should be made whether the deformity is supple or rigid. Supple metatarsus adductus is correctable passively. This is determined by stabilizing the heel while simultaneously abducting the forefoot. Hence, both deformities, i.e., heel valgus and forefoot adduction, are corrected together. Frequently, by stimulation of the lateral border of the foot by an

examiner's finger, the cooperative infant will actively correct the supple deformity through stimulation of the peroneal musculature. Fixed or rigid deformities are those which are not fully, passively correctable.

TREATMENT

Treatment is dependent upon whether the deformity is supple or rigid. In a large series, the ratio of supple to rigid metatarsus adductus was about 10:1.⁷ Rigid metatarsus adductus requires serial casting after the manner of Ponseti, by an experienced orthopaedic surgeon, and will not be discussed further.⁷ Supple metatarsus adductus usually requires no specific form of therapy, other than discouraging postures of sitting or sleeping as noted above. Parents need not be instructed in passive stretching exercises. Reverse last shoes or reversing the shoes on the feet of a child will not correct the deformity and may accentuate heel valgus. A Denis Browne splint is not used for similar reasons. As in femoral anteversion and internal tibial torsion, supple metatarsus adductus will usually correct spontaneously in time. Hence, reassurance is given to the parents.

CONCLUSION

The problem of toeing-in in an otherwise normal child is frequently compounded by the concerns of anxious parents. Through an understanding of the underlying factors in conjunction with a systematic physical examination, a proper diagnosis will be made. Hence, appropriate treatment and reassurance can be instituted for both the parents and the child.

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The Iowa Physician's Assistant

The emergence of the physician's assistant has brought both praise and questions. This discussion is a summary of a "position paper" prepared by the Iowa Physician's Assistant Society. It is provided for physician reading on recommendation of the Iowa Medical Society Committee on Delivery of Health Services.

AN IOWA LAW was enacted in 1971 to authorize the physician's assistant (PA) to work under the supervision of a licensed physician. The law assigned responsibility for PA regulation to the State Board of Medical Examiners (SBME). State rules and regulations applicable to the PA program were developed subsequently and are now in effect. The intent of this total effort has been to provide for the orderly, productive and qualitative use of the PA.

The first Iowa PAs began work in 1972. By 1973 there were about 15 PAs in the state. At present (September 1978) there are approximately 120 national board certified PAs approved by the SBME to work for a sponsoring Iowa physician.

A full understanding of the training, functions, legal standing and proper role of the PA is important. Of concern has been a belief the PA may be functioning (or may desire to function) as an independent health practitioner. Pursuant to this, the Iowa Physician's Assistant Society is seeking to offer information to clarify misconceptions and achieve a better understanding of the PA concept.

EMERGENCE OF THE PA

In 1970 the American Medical Association defined the PA as follows: *The physician's assistant is a skilled person qualified by academic and practical training to provide patient services under the supervision and direction of a licensed physician who is responsible for the performance of that assistant.*

Historically, the concept of the physician's assistant (with the delegation of tasks) is long lived. Physician delegation of duties to nurses and medical assistants has occurred for years. What is new is the development of formal training programs to prepare personnel to extend the physician's capabilities in the diagnostic and therapeutic management of patients.

The first formal PA training began in 1965 at Duke University. Several additional programs emerged in the ensuing five years. Less than 200 PAs had been graduated nationally by 1971. These first formally trained PA's drew a public and professional response sufficient to spur passage of the Comprehensive Health Manpower Training Act of 1971 which funded additional PA training programs.

Today, these PA education programs are standardized and accredited by the American Medical Association's Council on Medical Education and the Association of Physician Assistant Programs. The programs are subject to periodic review and reaccreditation by the AMA. Graduate PA's must pass a national certification examination from the National Board of Medical Examiners. Continuing education requirements have been imposed by the National Commission on Certification of Physician's Assistants and the American Academy of Physician's Assistants. They include 100 hours of continuing education every two years and a recertification exam every six years.

In 1971 the AMA Council on Medical Education established the "Essentials of an Approved Education Program for the Assistant to the Primary Care Physician." These standards now guide the development and self-evaluation of formal PA training programs.

The PA program at the University of Iowa College of Medicine is an excellent model of an AMA

accredited training program. Table I provides a breakdown of the 90 PA graduates of the U. of I. program with their overall ranking in national examination performance (now among 50 programs).

TABLE I
UNIVERSITY OF IOWA
PHYSICIAN'S ASSISTANT GRADUATES

Year	Na.	Ranking in National Exam
1974	10	4th
1975	17	3rd
1976	18	2nd
1977	25	2nd
1978	20	—

TABLE II
U. OF I. PA CURRICULUM

PHASE 1

Essentially didactic and specifically for PA students (except pharmacology and human pathology). Courses are taught by faculty from appropriate departments in the College of Medicine. Following are the basic medical science courses completed by the PA student:

Grass Human Anatomy	Human Physiology
Biochemistry	Human Pathology
Clinical Pathology	Microbiology
Pharmacology	Law & Medicine

PHASE 2

Introduction to Clinical Medicine and Physical Diagnosis

This course correlates and integrates basic science core information with clinical experiences. It is taken in conjunction with medical students and provides PA students the same clinical core background the medical student acquires for subsequent clinical training.

PHASE 3

One year of supervised clinical preceptorships is included in the following required and elective specialties:

	Na. of Weeks
REQUIRED (40 weeks)	
Family Practice	12
General Surgery	6
Internal Medicine	6
Pediatrics	6
Ob/Gyn	6
Psychiatry	4
ELECTIVE (8 weeks)	
Emergency Room	4
Radiology	2
Dermatology	2
Orthopedics	2
Urology	2
Rehab. Medicine	2

TRAINING PROGRAMS

Admission — Candidates applying to the Iowa program must have a minimum of two years' college to include skill requirements, core courses and specific science courses. Applicants must additionally have patient contact experience sufficient to comprehend their future role as dependent practitioners. Those admitted to the U. of I. have had from 12 to 24 months of previous health care experience and more than 70% of all applicants selected for admission have the baccalaureate degree prior to entry.

Curriculum — The U. of I. PA training program lasts 24 months. The curriculum is divided into three distinct phases. These phases are highlighted in Table II.

When the PA student completes the training program he receives a formal certificate. When the student finishes the baccalaureate requirements he/she receives a bachelor of science degree from the College of Medicine.

LAWS & RULES

The State Board of Medical Examiners is charged with regulation of PA's. Both the PA and his physician employer must apply for registration with the SBME through a dual process. In his application the sponsoring physician lists the qualifications of the PA, his own specialty and professional background, and a description of how the PA is to be used. One physician may supervise no more than two PAs.

Iowa law states each applicant for approval to be a PA must be a graduate of an approved program or present other evidence of equivalent education and training approved by the SBME. The applicant must also pass the national exam and be of good moral character. All physician/PA teams must re-register with the SBME annually.

Iowa law further declares a PA may render medical services under supervision of a licensed physician. The exact meaning of the term "supervision" has been of some concern. Iowa law defines the terms "supervision" and "supervising physician" as follows:

Supervising physician: "a physician approved by the board to supervise and be responsible for a particular assistant to the physician, who evaluates his patient's total health care needs and who accepts initial and continuing responsibilities therefor."

Supervision: "the responsibility of the supervising physician to retain authority for patient

care, although the physician need not be physically present at each activity of the assistant, nor be specifically consulted before each delegated task is performed."

The main concern of Iowa physicians, as reflected in a resolution approved by the 1978 Iowa Medical Society House of Delegates, is that PAs are seeking to become independent practitioners. The Iowa Physician's Assistant Society believes this impression derives from the fact that some PA's function in settings apart from that of the supervising physician. Only a small percent (less than 10%) of the Iowa PAs work in satellite clinics. The contention of the IPAS is that by so doing the PA is filling a vital role in rural communities by extending the capabilities of the supervising physician where before such services were not readily accessible.

Special permission of the SBME is required

before a satellite clinic can be established. Iowa law stipulates permission to use a PA at a remote site may be given by the SBME if (a) there is a demonstrated need for such utilization; (b) adequate provision for immediate communication exists between the physician and the PA; (c) there is a mechanism to establish a direct patient-physician relationship for patients seen initially by the PA; (d) a responsible physician spends at least two one-half days per week in the remote office, and (e) adequate supervision and review of the work of the PA is provided.

Once use of a PA in a satellite clinic is approved by the SBME, Iowa law declares: (a) the supervising physician shall review at least weekly all patient care provided by the PA if such care is rendered without direct consultation with the physician and he/she shall countersign all notes made by the PA; (b) in the temporary absence of

IMS CONSIDERATION OF THE PA

At its meeting on November 16, 1978, the Iowa Medical Society Executive Council approved a report from the Committee on Delivery of Health Services which contained the following observations and recommendations:

1. The action of the 1978 House of Delegates calling on the IMS to "actively seek to limit the work of the PA and FNP to the same facility where the physician is in attendance" has been reported officially to the Board of Medical Examiners, the Board of Nursing, The Iowa Nurses' Association and the Iowa Physician's Assistant Society.

2. The Committee on Delivery of Health Services feels the 1978 House action needs clarification and/or further interpretation. For example, the reference to "same facility where the physician is in attendance" should be more clearly defined. The committee has received information indicating quality care is being rendered by PA's under properly supervised situation, and the BME is maintaining active surveillance of the PA program. In light of this information, it may be appropriate to recommend to the House that it consider a modification in its present position. This possibility will be considered as the committee carries out a directive from the 1978 House to "maintain surveillance over developments in this

area, and file reports with the Executive Council and the House of Delegates."

3. The IMS should encourage its members to submit specific complaints re abuses of the PA program by PA's and/or their supervising physicians to the Board of Medical Examiners for appropriate investigation, evaluation and action.

4. Actions that might be taken by the BME in response to legitimate complaints against PA's and/or their supervising physicians should be applied only to the PA or physician involved, not to all PA's, nor to all physicians supervising PA's.

5. If additional personnel are needed by the BME to implement the above recommendation, then the IMS should support legislation to appropriate the necessary funds.

6. The IMS, the BME, and the U. of I. College of Medicine should cooperate in educational projects to keep IMS members apprised of PA and FNP activities and developments. IMS publications should be used for this purpose, along with presentations to county medical societies.

The IMS Committee on Delivery of Health Services will present a Supplemental Report to the House of Delegates in April with any further specific recommendations and recent information on the utilization of PAs.

the supervising physician, the PA may carry out tasks for which he is registered, if the supervisory and review mechanisms are provided by a delegated alternative physician supervisor, and (c) the PA may not function as such if these supervisory and review functions are impossible.

The IPAS acknowledges the satellite clinic concept may appear initially to allow a greater degree of PA autonomy. However, reference is made to a recent Iowa study which discounts this. It indicated no difference in amount of time the PA spent conferring with the supervising physician whether in a satellite clinic or a primary practice site. The need for appropriate and adequate physician supervision is emphasized in the PA training program with both sponsoring physician and PA sharing responsibility for this supervisory status.

QUALITY ASPECTS

Better use of physician time and improved medical care are benefits usually cited from PA staffing. More time is noted as being available for the physician to address the more complex medical problems. And various studies indicate good patient acceptance of the PA.

Further investigations have demonstrated no significant difference in morbidity or outcome in primary care service delivered by the physician/PA team. Moreover, other informed sources have found no indication that incorporating a PA into a practice setting increases the likelihood of liability. And some commentators have declared the presence of a PA will reduce malpractice risks.

COST OF CARE

According to the IPAS position paper, the PA has had a positive impact on the economics of medical care delivery. Several studies are cited to support cost efficiency. The idea of a differential in the fee for PA services versus physician services was discounted, the contention being the quality of care is not jeopardized.

In summary, the thought is projected that use of the PA can reduce medical cost by (a) maintaining and increasing productivity in lieu of raising patient care costs; (b) reducing the frequency of hospitalization by stressing preventive medicine, and (c) taking into account the reduced

formal education costs of medical personnel.

ACCESS TO CARE

Reference is made to the medical manpower problem which has faced the country in recent years. The distribution element of the problem is emphasized with more than 83% of the primary care physicians in metropolitan areas. The paper notes that only 12.8% of all primary care physicians are in rural areas as compared to more than 33% of the PA's. Studies are cited to indicate Iowa has a concentration of physicians (half in six counties) in areas of greater population. This was contrasted by reference to 40% of the PAs being in communities of 10,000 or less.

No suggestion is made that PAs are the total answer to manpower problems but the contention is that their presence is part of the solution. The idea is offered that the presence of PAs makes it more likely a physician will establish a rural practice because the PA is capable of performing many routine tasks to enable the physician to extend quality care to more people and also gain a greater measure of freedom.

CONCLUSION

The position paper concludes by emphasizing the PA is (1) assistant to and dependent on the employer physician with all formal education so directed; (2) trained to identify with physicians in modes of thought, patterns of action and reaction, and dedication to moral and ethical value systems, and (3) prepared to assume appropriate responsibility.

The studies support a belief that mid-level health practitioners can be trained to extend physicians' capabilities in delivery of care to rural and other underserved areas without sacrificing quality or increasing cost. Moreover, the IPAS report states there has been no evidence to support the belief that PA's wish to function as independent practitioners.

As submitted to the Iowa Medical Society, and as summarized here, the position paper of the Iowa Physician's Assistant Society attempts to clarify existing misconceptions about PAs from the perspective of the IPAS. The concluding hope is expressed that PA's will be able to serve the health care needs of Iowans working under the direction and supervision of licensed physicians.

Renal Agenesis Associated With a Congenitally Absent Vas Deferens

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In this brief report, the authors describe three cases to illustrate potential association between congenitally absent vas deferens and urologic anomalies. Particular reference is made to ipsilateral renal agenesis.

MALE STERILIZATION by vasectomy has become an increasingly popular procedure during the past few years. As a consequence, careful examination and exploration of scrotal contents has become more frequent, with an associated increase in the findings of congenitally absent vas deferens. While this is still a rare anomaly, its association with urologic anomalies, particularly ipsilateral renal agenesis, prompts us to report three cases discovered during this fairly routine procedure.

CASE REPORTS

Case 1: J. P., a 32-year-old male, was known to have a congenitally absent left kidney. X-ray studies showed no evidence of a functioning left kidney; the right kidney and ureter were normal in appearance. At the time of vasectomy the left scrotal compartment contained a normal testicle but no vas deferens. A right vasectomy was done.

Case 2: R. H. is a 46-year-old male. During surgery to repair a right inguinal hernia, the vas

deferens could not be found. A specimen from the right cord failed to demonstrate the vas. A left vasectomy was done without difficulty. Subsequent IVP exhibited no function of the right kidney. The left kidney demonstrated prompt excretion though it was slightly enlarged, probably on the basis of a compensatory hypertrophy. The left collecting system and the left ureter were normal.

Case 3: D. S., a 31-year-old male, was found to have no vas deferens on the left side, in spite of careful dissection of the cord. The right vas was normal. Subsequent IVP showed nonfunction of the left, considered secondary to absence of the kidney on that side. On the right was seen a single kidney with compensatory hypertrophy, normal collecting system and normal ureter.

EMBRYOLOGY

The urinary system begins its development with two provisional organs. The pronephros is soon replaced by the mesonephros, which in turn is replaced by the metanephros, or permanent kidney. At the 4 mm embryologic stage, the mesonephric or Wolffian duct develops the ureteric bud which differentiates into the renal pelvis, calices, collecting system and ureters of the permanent kidney. The testes develop from the urogenital ridge which arises medial to the mesonephric tubules at the 8 mm stage. The cranial end of the Wolffian duct convolutes and elongates at the 60 mm stage to form the duct of the epididymis. The caudal end of the Wolffian duct later develops a thick mesodermal muscular coat

(Continued on page 98)

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RENAL AGENESIS ASSOCIATED WITH A CONGENITALLY ABSENT VAS DEFERENS

(Continued from page 97)

and becomes the vas deferens; the seminal vesicles and ejaculatory duct also differentiate from this part of the Wolffian duct.

DISCUSSION

It becomes apparent that if there is a disturbance of development at or before the 4 mm stage, both the Wolffian duct and its ureteric bud will be affected. This disturbance will result in anomaly or absence of the vas deferens (and related structures as noted above), plus ipsilateral renal dysgenesis or agenesis. By the time the 60 mm stage is reached, however, the ureteric bud has already differentiated. Thus, a disturbance at this time would not affect the renal system; but the vas, seminal vesicle, and ejaculatory ducts, which are still developing, would be afflicted.

The incidence of absent vas in the general population, based on vasectomy studies, is 0.5-1.0%.² A search of the literature revealed only seven cases similar to ours,^{3, 5-7} plus mention of 14 others.^{1, 2, 8-11} Despite the relative rarity of the anomaly, the significance of an absent kidney is considerably greater than that of an absent vas, and one should not overlook the association of the two. Additionally, in children, there is an association between absent vas deferens and cystic fibrosis.^{2, 12, 13} Routine examination of the spermatic cord, even in patients not desiring vasectomy, may reveal patients with absent vas and these individuals may deserve additional evaluation. It is apparent that an absent vas deferens is rarely an isolated finding. Its discovery always merits further investigation.

REFERENCES

The references noted with this paper are available either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

AUXILIARY INVITATION . . . Society members are invited to help the IMS Auxiliary celebrate its 50th anniversary Friday, April 20. The celebration will include a dinner-dance, preceded by cocktails, at the Des Moines Hilton Inn. Reservations may be made by calling Sandy Nichols at 1/800-422-3070. The event will occur in connection with the annual meeting of the IMS House of Delegates.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecostasia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride) One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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Editorials

M. E. ALBERTS, M.D., Scientific Editor

CHANGE

This morning I saw a tulip in full bloom. Though it was a potted tulip, forced to bloom before its natural time, it was a welcome harbinger of spring. At this time of year while the miseries of a severe winter are still upon us it is refreshing to see the potted spring flowers which patients receive from friends. The tulips and hyacinths, the daffodils and iris, the azaleas and cinerarias replace the mums, poinsettias and hot-house roses. Spring must be forthcoming, and the transition from a dreary winter to the dynamic spring will change our attitudes and expectations. So it is with all transitions from one state of being to another, and we must adjust to the change and cope with whatever it brings.

The delivery of health care is in a vast transitional stage, and there are those who desire it to be much more changed. Our designation as *vendors of health care* (I detest that term) has placed us in a position of being providers of a commodity rather than being traditional practitioners of medicine. The practice of medicine is not the selling of goods. It is learned use of the art of medicine. It is the application of scientific truths to promote good health or alleviate illness according to the specific situation. We practice preventive medicine and we practice therapeutic medicine; they are inseparable. Yet in the eyes of some insurers, preventive medicine (which might entail diagnostic procedures) is not "covered," and we must act as public relations experts to explain to our patients what the insurance people should have clearly delineated to their policyholders. True, patients should be responsible for knowing the limitations of their insurance cover-

age, but who reads those complicated policies anyway?

The government constantly strives to change our manner of delivering health care. Our busy days are complicated by the need (1) to comply with untold numbers of regulations, and (2) to complete forms to satisfy someone at an administrative level. Forces continually edge forward to further governmental involvement in medicine to a final state of total governmental control and ultimate disorganization. Our times have changed, and we will change with the times, but let us hope we can maintain some control over our destiny. I like two quotations from Abraham Lincoln that seem appropriate in this concern. (1) "You cannot build character and courage by taking a man's initiative and independence." (2) "You cannot help men permanently by doing for them what they could and should do for themselves."

We as physicians should be strong to our tradition of providing good health care in an honest, unselfish manner. We cannot weaken our methods of good health care and expect to strengthen the deficiencies. Politicians and pseudorighteous persons who think they know all the answers must not be given the opportunity to create monsters which will not alleviate deficiencies which admittedly may be present. It seems strange the ultra wealthy politicians are such strong advocates of national health care programs. Can their concerns be totally altruistic, or is there a method in their madness?

Yes, change is upon us. Shall it be a gradual, logical, sensible change for the common good, or will it be a senseless, abrupt, unfettered change which will make a monstrous shambles of present medical care? Change is inevitable, like spring follows winter, but unlike the weather, we can do something about medical care for the people of our good land. — M.E.A.

RANDOM RAMBLINGS

High level aides in federal government appear to be devoting many hours each day to their labors. Their family stability is even weakened by extended work schedules. Marriages suffer as the policymakers labor long and hard. Perhaps all of us would profit, and their marriages would be happier, if the governmental zealots would stay within the 40-hour week and curtail their formulation of new regulations and policies. Already we are overburdened by the bureaucratic brainstorm. Go home, young man; tend to your family and relieve us of the complications you impose on our happiness and livelihood.

• • •

That reminds me of another story published recently in our local newspaper. It seems that statistics, however formulated, tend to show the crime rate in Congress is higher than in one of our larger cities. It is frightening to think we elect people to high office and then discover their trust is prone to tarnish. Most officeholders are true to their trust; others however seem bent on serving themselves. Ironically, when not re-elected many still obtain top level positions.

Did you see the news release about the course in competitive decision making being taught at the Harvard Business School? The headlines proclaimed that "... telling lies becomes a matter of course." Apparently the crux of the course is a concern for what is ethically right when it sometimes conflicts with what may be economically or strategically beneficial. The professor states his course "deals with real-world problems, among them lying for advantage." It is known as "strategic misrepresentation." If such is to be our ethic in the business world, already a matter of course in some governmental circles, what of the professional fields? Let us physicians always be true to our trust, be honest with each other and to our patients and friends. Our world has enough deceit and dishonesty without it being taught — even if for strategic economic gain.

• • •

On a brighter note it is time to remind our member physicians the Iowa Medical Society House of Delegates will convene in Des Moines on April 21-22. Your delegates represent you, and their votes should be based on your input. If no communication exists between the delegates and their constituents little exchange of thought and opinion can occur. Each member of our Society is

(Please turn to page 106)

★

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Educationally Speaking

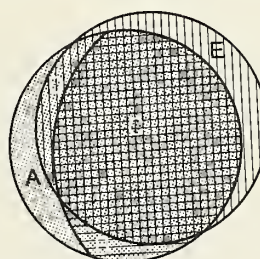
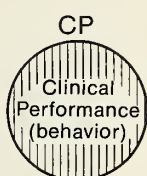
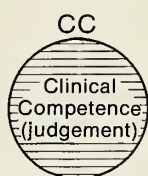


by R. M. CAPLAN, M.D.

THE FABLE OF THE THREE CIRCLES

Sometimes people think I'm too wordy. So, as an antidote, here is a continuing education story

told in a different way: Once upon a time there were three circles. Even today, when we superimpose them in a certain way, and study them, they permit us to read for ourselves the kind of physician we have become.



We can see that:

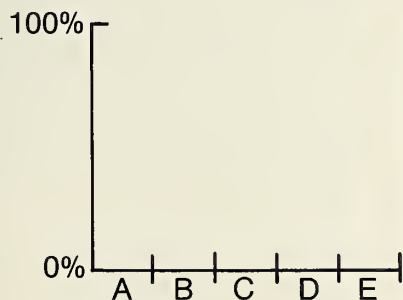
	K&S	CC	CP
A	✓	0	0
B	✓	✓	0
C	✓	✓	✓
D	✓	0	✓
E	0	0	✓

Influence on Patient Care

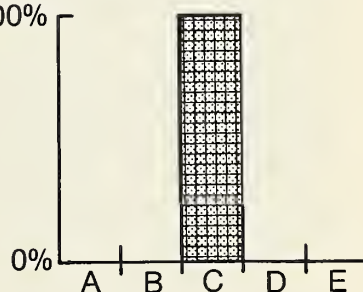
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0
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My self-estimate of how I practice (fill blanks and plot on graph):

As I Am
A _____ %
B _____ %
C _____ %
D _____ %
E _____ %



As I'd Wish To Be 100%
A 0 %
B 0 %
C 100 %
D 0 %
E 0 %



Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

State Department of Health

NEW RECOMMENDED TREATMENT SCHEDULES FOR GONORRHEA

The U. S. Public Health Service recently convened a group of consultants to review therapy for gonorrhea and prepared the treatment schedules which follow. Included are specific regimens for treatment of pharyngeal infections, gonorrhea in pregnant patients, resistant strains, acute salpingitis, pediatric patients, gonococcal ophthalmia and disseminated gonococcal disease.

GONORRHEA

CDC Recommended Treatment Schedules,* 1979

UNCOMPLICATED GONOCOCCAL INFECTIONS IN MEN AND WOMEN

Drug Regimens of Choice

Aqueous procaine penicillin G (APPG): 4.8 million units injected intramuscularly at 2 sites, with 1.0 g of probenecid by mouth. OR

Tetracycline hydrochloride:† 0.5 g by mouth 4 times a day for 5 days (total dosage 10.0 g). Other tetracyclines are not more effective than tetracycline hydrochloride. All tetracyclines are ineffective as a single-dose therapy. OR

Ampicillin or amoxicillin: Ampicillin, 3.5 g, or amoxicillin, 3.0 g, either with 1 g probenecid by

* These recommendations were established after deliberation with these therapy consultants: H. C. Neu, M.D., College of Physicians and Surgeons, Columbia University; E. H. Braff, M.D., San Francisco Dept of Public Health; G. Cunningham, M.D., Southwestern Medical School, Dallas; K. K. Holmes, M.D., Ph.D., USPHS Hospital, Seattle; F. Judson, M.D., Dept of Health and Hospitals, Denver; W. McCormack, M.D., State Laboratory Institute, Boston; E. M. Mears, Jr, M.D., New England Medical Center, Boston; J. D. Nelson, M.D., Southwestern Medical School, Dallas; M. Nelson, M.D., Orange County, Calif.; S. M. Sgroi, M.D., Suffield, Conn.; F. Sparling, M.D., School of Medicine, The University of North Carolina, Chapel Hill; Lt. Col. E. C. Tramont, Walter Reed Army Medical Center, Washington, D.C.

† Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.

U.S. Department of Health, Education, and Welfare/Public Health Service.

Note: Physicians are cautioned to use no less than the recommended dosages of antibiotics. The major change from the 1974 published treatment schedule is that there are now 4 drug regimens which can be used for the treatment of uncomplicated gonorrhea.

mouth. Evidence shows that these regimens are slightly less effective than the other recommended regimens.

Patients who are allergic to the penicillins or probenecid should be treated with oral tetracycline as above. Patients who cannot tolerate tetracycline may be treated with spectinomycin hydrochloride, 2.0 g, in 1 intramuscular injection.

Special Considerations

Single-dose treatment is preferred in patients who are unlikely to complete the multiple-dose tetracycline regimen. The APPG regimen is preferred in men with anorectal infection.

Pharyngeal infection is difficult to treat. High failure rates have been reported with ampicillin and spectinomycin.

Tetracycline treatment results in fewer cases of postgonococcal urethritis in men. It may eliminate coexisting chlamydial infections in men and women.

Patients with incubating syphilis (seronegative, without clinical signs of syphilis) are likely to be cured by all the above regimens except spectinomycin. All patients should have a serologic test for syphilis at the time of diagnosis.

Patients with gonorrhea who also have syphilis or are established contacts of syphilis patients should be given additional treatment appropriate to the stage of syphilis.†

(Please turn to page 103)

† Editor's Clarification: Patients who are contacts to a proven case of early syphilis should be treated as for early syphilis, regardless of the regimen given for gonococcal infection.

STATE DEPARTMENT OF HEALTH*(Continued from page 102)*

Treatment of Sexual Partners

Men and women exposed to gonorrhea should be examined, cultured, and treated at once with one of the regimens above.

Follow-up

Follow-up cultures should be obtained from the infected site(s) 3-7 days after completion of treatment. Cultures should be obtained from the anal canal of all women who have been treated for gonorrhea.

Treatment Failures

The patient who fails therapy with penicillin, ampicillin, amoxicillin, or tetracycline should be treated with 2.0 g of spectinomycin intramuscularly.

Most recurrent infections after treatment with the recommended schedules are due to *reinfection* and indicate a need for improved contact tracing and patient education. Since infections by penicillinase (B-lactamase)-producing *Neisseria gonorrhoeae* is a cause of treatment failure, post-treatment isolates should be tested for penicillinase production.

Not Recommended

Although long-acting forms of penicillin (such as benzathine penicillin G) are effective in syphilotherapy, they have NO place in the treatment of gonorrhea. Oral penicillin preparations such as penicillin V are not recommended for the treatment of gonococcal infection.

**PENICILLINASE-PRODUCING
NEISSERIA GONORRHOEAE (PPNG)**

Patients with uncomplicated PPNG infections and their sexual contacts should receive spectinomycin, 2.0 g, intramuscularly in a single injection. Because gonococci are very rarely resistant to spectinomycin and reinfection is the most common cause of treatment failure, patients with positive cultures after spectinomycin therapy should be re-treated with the same dose.

A PPNG isolate that is resistant to spectinomycin may be treated with cefoxitin, 2.0 g, in a single intramuscular injection, with probenecid, 1.0 g, by mouth.

TREATMENT IN PREGNANCY

All pregnant women should have endocervical cultures for gonococci as an integral part of the

prenatal care at the time of the first visit. A second culture late in the third trimester should be obtained from women at high risk of gonococcal infection.

Drug regimens of choice are APPG, ampicillin, or amoxicillin, each with probenecid as described above.

Women who are allergic to penicillin or probenecid should be treated with spectinomycin.

Refer to the sections on acute salpingitis and disseminated gonococcal infections for the treatment of these conditions during pregnancy. Tetracycline should not be used in pregnant women because of potential toxic effects for mother and fetus.

**ACUTE SALPINGITIS
(PELVIC INFLAMMATORY DISEASE)**

There are no reliable clinical criteria to distinguish gonococcal from nongonococcal salpingitis. Endocervical cultures for *N. gonorrhoeae* are essential. Therapy should be initiated immediately.

Hospitalization

In the following situations, hospitalization should be strongly considered: uncertain diagnosis, in which surgical emergencies such as appendicitis and ectopic pregnancy must be excluded; suspicion of pelvic abscess; severe illness; pregnancy; inability of patient to follow or tolerate an outpatient regimen; or failure of patient to respond to outpatient therapy.

Antimicrobial Agents

*Outpatients: Tetracycline:** 0.5 g, taken orally 4 times a day for 10 days. This regimen should not be used for pregnant patients. *OR APPG:* 4.8 million units intramuscularly, ampicillin, 3.5 g, or amoxicillin, 3.0 g, each with probenecid, 1.0 g. Either regimen is followed by ampicillin, 0.5 g, or amoxicillin, 0.5 g, orally 4 times a day for 10 days.

Hospitalized patients: Aqueous crystalline penicillin G: 20 million units given intravenously each day until improvement occurs, followed by ampicillin, 0.5 g, orally 4 times a day to complete 10 days of therapy. *OR Tetracycline:** 0.25 g, given intravenously 4 times a day until improvement occurs, followed by 0.5 g orally 4 times a day to complete 10 days of therapy. This regimen should not be used for pregnant women. The dosage may have to be adjusted if renal function is depressed.

(Please turn to page 105)

* Food and some dairy products interfere with absorption. Oral forms of tetracycline should be given 1 hour before or 2 hours after meals.



A reminder

ZYLOPRIM[®]

(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim[®] (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy, particularly in patients with pre-existing liver disease. Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol[®] (mercaptopurine) or Imuran[®] (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim[®] (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or sub-normal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim[®] (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yü for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000, 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent)



Wellcome

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Research Triangle Park
North Carolina 27709

STATE DEPARTMENT OF HEALTH

(Continued from page 103)

Since optimal therapy for hospitalized patients has not been established, other antibiotics in addition to penicillin are frequently used.

Special Considerations

Failure of the patient to improve on the recommended regimens does not indicate the need for stepwise additional antibiotics, but requires clinical reassessment.

The intrauterine device is a risk factor for the development of pelvic inflammatory disease. The effect of removing an intrauterine device on the response of acute salpingitis to antimicrobial therapy and on the risk of recurrent salpingitis is unknown.

Adequate treatment of women with acute salpingitis must include examination and appropriate treatment of their sex partners because of their high prevalence of nonsymptomatic urethral infection. Failure to treat sex partners is a major cause of recurrent gonococcal salpingitis.

Follow-up of patients with acute salpingitis is essential during and after treatment. All patients should be recultured for *N. gonorrhoeae* after treatment.

ACUTE EPIDIDYMITIS

Acute epididymitis can be caused by *N. gonorrhoeae*, *Chlamydia*, or other organisms. If gonococci are demonstrated by Gram stain or culture of urethral secretions, treatment should be APPG, 4.8 million units, ampicillin, 3.5 g, or amoxicillin, 3.0 g, each with probenecid, 1.0 g. Either regimen is followed by ampicillin, 0.5 g, or amoxicillin, 0.5 g, orally 4 times a day for 10 days, OR tetracycline,* 0.5 g, orally 4 times a day for 10 days.

If gonococci are not demonstrated, the above tetracycline regimen should be used.

DISSEMINATED GONOCOCCAL INFECTION

Treatment Schedules

There are several, equally effective treatment schedules in the arthritis-dermatitis syndrome. These include the following.

Ampicillin/amoxicillin: ampicillin, 3.5 g, or amoxicillin, 3.0 g, orally, each with probenecid, 1.0 g, followed by ampicillin 0.5 g, or amoxicillin, 0.5 g, 4 times a day orally for 7 days. OR

*Tetracycline:** 0.5 g, orally 4 times a day for 7

days. Tetracycline should not be used for complicated gonococcal infection in pregnant women. OR

Spectinomycin: 2.0 g, intramuscularly twice a day for 3 days (treatment of choice for disseminated infections caused by PPNG). OR

Erythromycin: 0.5 g, orally 4 times a day for 7 days. OR

Aqueous crystalline penicillin G: 10 million units intravenously per day until improvement occurs, followed by ampicillin, 0.5 g, 4 times a day, to complete 7 days of antibiotic treatment.

Special Considerations

Hospitalization is indicated in patients who may be unreliable, have uncertain diagnosis, or have purulent joint effusions or other complications.

Open drainage of joints other than the hip is not indicated. Intra-articular injection of antibiotics is unnecessary.

Meningitis and Endocarditis

Meningitis and endocarditis caused by the gonococcus require high-dose intravenous penicillin therapy. In penicillin-allergic patients with endocarditis, desensitization and administration of penicillin are indicated. Chloramphenicol may be used in penicillin-allergic patients with meningitis.

GONOCOCCAL INFECTIONS IN PEDIATRIC PATIENTS

With gonococcal infections in children beyond the newborn period, the possibility of sexual abuse must be considered. Genital, anal, and pharyngeal cultures should be obtained from all patients before antibiotic treatment. Appropriate cultures should be obtained from individuals who have had contact with the child.

PREVENTION OF GONOCOCCAL OPHTHALMIA

When required by state legislation or indicated by local epidemiologic considerations, effective and acceptable regimens for prophylaxis of neonatal gonococcal ophthalmia include ophthalmic ointment or drops containing tetracycline or erythromycin OR a 1% silver nitrate solution.

Special Considerations

Bacitracin is not recommended. The value of irrigation after application of silver nitrate is unknown.

(Please turn to page 106)

(Continued from page 105)

MANAGEMENT OF INFANTS BORN TO MOTHERS WITH GONOCOCCAL INFECTION

The infant born to a mother with gonorrhea is at high risk of infection and requires treatment with a single intravenous or intramuscular injection of aqueous crystalline penicillin G, 50,000 units to full-term infants or 20,000 units to low-birth-rate infants. Topical prophylaxis for neonatal ophthalmia is not adequate treatment. Clinical illness requires additional treatment.

NEONATAL DISEASE

Gonococcal Ophthalmia

Patients should be hospitalized and isolated for 24 hours after initiation of treatment. Untreated gonococcal ophthalmia is highly contagious. Aqueous crystalline penicillin G, 50,000 units/kg/day, in 2 doses intravenously should be administered for 7 days. Saline irrigation of the eyes should be performed as needed. Topical antibiotic preparations alone are not sufficient or required when appropriate systemic antibiotic therapy is given.

Complicated Infection

Patients with arthritis and septicemia should be hospitalized and treated with aqueous crystalline penicillin G, 75,000 to 100,000 units/kg/day, intravenously in 2 or 3 divided doses for 7 days. Meningitis should be treated with aqueous crystalline penicillin G, 100,000 units/kg/day, divided into 3 or 4 intravenous doses, and continued for at least 10 days.

CHILDHOOD DISEASE

Children who weigh 100 lbs. (45 kg) or more should receive adult regimens. Children who

weigh less than 100 lbs. should be treated as follows.

Uncomplicated Disease

Uncomplicated vulvovaginitis, urethritis, proctitis, or pharyngitis can be treated at 1 visit with amoxicillin, 50/kg, orally with probenecid, 25 mg/kg (maximum 1.0 g), OR with aqueous procaine penicillin G, 100,000 units/kg, intramuscularly plus probenecid, 25 mg/kg (maximum 1.0 g).

Special Considerations

Topical and/or systemic estrogen therapy are of no benefit in vulvovaginitis. Long-acting penicillins, such as benzathine penicillin G, are not effective. All patients should have follow-up cultures, and the source of infection should be identified, examined, and treated.

Gonococcal Ophthalmia

Ophthalmia in children is treated as in neonates, but the dose of penicillin is increased to 100,000 units/kg/day intravenously.

Complicated Infections

Patients with peritonitis or arthritis require hospitalization and treatment with aqueous crystalline penicillin G, 100,000 units/kg/day, intravenously for 7 days. Aqueous crystalline penicillin G, 250,000 units/kg/day, intravenously in 6 divided doses for at least 10 days, is recommended for meningitis.

Allergy to Penicillins

Children who are allergic to penicillins should be treated with spectinomycin, 40 mg/kg, intramuscularly. Children older than 8 years may be treated with tetracycline, 40 mg/kg/day, orally in 4 divided doses for 5 days. For treatment of complicated disease, the alternative regimens recommended for adults may be used in appropriate pediatric dosages.

RANDOM RAMBLINGS

(Continued from page 100)

urged to speak freely and frankly about any issue brought before the House of Delegates. Your delegates desire your input; give them an opportunity to be truly your representative.

• • •

One last item: scientific journals will become a more popular target for the Internal Revenue Service, the Interstate Commerce Commission,

and the U. S. Post Office. JAMA Editor William R. Barclay, M.D., observes that "Respect for scientific achievement appears to be waning in this country, and there are signs of antielitism in the government agencies, indifference to science in the executive branch of government, and hostility among some members of Congress."

Scientific journals represent an effective means of communication for scientists. If increasing numbers of journals are frozen out of the market by governmental regulations and economic barriers, future development of scientific advances may suffer irreparable reverses. — M.E.A.

January 1979 Morbidity Report

Disease	Jan. 1979 Total	1979 to Date	1978 to Date	Most Jan. Cases Reported From These Counties
Amebiasis	7	7	0	Boone, Polk
Brucellosis	1	1	0	Buchanan
Chickenpox	970	970	572	Scattered
Encephalitis, viral	2	2	1	Linn, Webster
Giardiasis	6	6	2	Iowa, Scott, Lee, Boone, Clinton
Hepatitis, A	19	19	15	Scattered
Hepatitis, B	6	6	6	Johnson, Polk, Bremer, Woodbury
type unspecified	1	1	4	Blackhawk
Herpes simplex	3	3	6	Johnson, Corroll
Infectious mononucleosis	32	32	65	Scattered
Meningitis				
aseptic	10	10	1	Scattered
bacterial	14	14	4	Scattered
meningococcal	2	2	1	Linn, Dubuque
Mumps	1	1	10	Des Moines
Pertussis	0	0	0	NA

Disease	Jan. 1979 Total	1979 to Date	1978 to Date	Most Jan. Cases Reported From These Counties
Robies in animals	15	15	11	Scattered
Rubella				
(German measles)	0	0	3	NA
Rubeola (measles)	0	0	3	NA
Salmonella	8	8	10	Scattered
Shigella	7	7	1	Scott, Polk
Tuberculosis				
total ill	11	11	9	Scattered
bact. pos.	11	11	6	Scattered
Venereal diseases:				
Gonorrhea	462	462	524	Scattered
P. & S. Syphilis	3	3	2	Muscatine, Harrison, Pottawattomie

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Eaton's agent — 8, scattered; Erythema infectiosum — 13, Scott & Blackhawk; Cytomegalovirus isolated — 1, Delaware; Tinea capitis — 1, Linn; Rheumatic fever — 1, Ido; Gastroenteritis — 1071, scattered; Influenza-like illness (URI) — 4558, scattered; Kawasaki disease — 1, Scott.

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or Phone: (402) 346-9008

About IOWA Physicians

Dr. Stephen C. Paulk recently joined the Waterloo Surgical and Medical Group. A native of Harlan, Dr. Paulk received the M.D. degree at U. of I. College of Medicine and completed his surgery residency at University Hospitals in Iowa City. . . . **Dr. Sudhir Marfatia**, formerly of Tyler, Minnesota, has joined **Dr. Duane E. Mitchell** in Mount Ayr. A native of India, Dr. Marfatia received his medical education in Ahmedabad. He came to the United States in 1970 and took postgraduate work at Mount Sinai School of Medicine in New York, Massachusetts General Hospital in Boston, and St. Christopher's Hospital in Philadelphia. Prior to locating in Mount Ayr, Dr. Marfatia was in private practice in Tyler, Minnesota. . . . **Dr. John Graether**, Marshalltown, was guest speaker at the annual meeting of the Marshalltown Area Community Hospital Auxiliary. Dr. Graether presented a film on cataract surgery using the phaco-emulsification technique. The Marshalltown hospital was one of the first in the midwest to provide this type of cataract surgery. . . . **Dr. Thomas G. Walker**, Riceville physician for 46 years, retired February 5. Dr. Walker is the third generation of doctors to practice in Riceville. His retirement will end the Walker tenure at 90 years. Dr. Walker's grandfather, Dr. Hugh Walker began medical practice in Riceville in 1889. He was joined by his son, Dr. T. S. Walker in 1906 and the third generation, Dr. T. G. Walker, joined his father in 1933. Dr. Walker was recognized at a community open house on February 4.

Dr. Creighton B. Wright, professor in Department of Surgery at the U. of I. College of Medicine, is new president-elect of the Association for Academic Surgery. The Association includes 1500 members who are multispecialty surgeons at academic centers throughout the nation. Dr. Wright is a former member of the

Association's Executive Council. . . . **Dr. Richard L. Anderson** recently joined the emergency room staff at Keokuk Area Hospital. Dr. Anderson received the M.D. degree at the University of Utah and interned at Grove's LDS Hospital in Salt Lake City, Utah. Prior to locating in Keokuk, Dr. Anderson was director of the emergency department at Lutheran Hospital in Moline, Illinois. . . . New officers of the Scott County Medical Society are **Dr. Dennis L. Miller**, president; **Dr. Paul L. Rohlf**, president-elect; **Dr. William Barker**, vice president; **Dr. James Holte**, secretary; **Dr. Lawrence Hunter**, assistant secretary; and **Dr. Dan Bovenmyer**, treasurer. All are Davenport physicians. . . . **Dr. John E. Kelly**, Spencer, was guest speaker at a recent meeting of the Spencer Hy-Noon Kiwanis Club. Dr. Kelly spoke on the history of medicine in Spencer and Clay County from the early 1930's. . . . **Dr. Phillip Crew**, Cedar Rapids, is new chairman of the Linn County Board of Health.

Dr. Maurice Huffman, Carroll, was guest speaker at a recent meeting of the city's Welcome Wagon Club. Dr. Huffman's topic was "Preventing and Handling Household Emergencies." . . . **Dr. N. L. Krueger**, Casey, was honored by the community at an open house for his 20 years of medical service to area residents. . . . **Dr. A. Clark Hyden**, Sioux City, has been appointed to the Marian Health Center's divisional board. Dr. Hyden received the M.D. degree at Temple University in Philadelphia; interned in Los Angeles and had general surgery and internal medicine residencies at Riverside County Hospital and Santa Clara County Hospital, respectively, in California. He has been in Sioux City since 1966. . . . **Dr. John B. Dressler** has been named Ida Grove's "citizen of the year." The award was presented to Dr. Dressler at the annual

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banquet of the Ida Grove Chamber of Commerce. A graduate of the University of Nebraska Medical School, Dr. Dressler began his practice in Ida Grove in 1939 and retired in 1978. . . . **Dr. Kazim Fathie**, Cedar Rapids neurosurgeon, plans to close his practice in CR to relocate in Las Vegas, Nevada. A native of Tehran, India, Dr. Fathie has practiced in Linn County for 16 years. . . . Medical staff officers for 1979 at St. Anthony's Regional Hospital in Carroll are **Dr. James P. Jensen**, president; **Dr. Robert Q. Christensen**, vice president; and **Dr. Stuart H. Nam**, secretary-treasurer. All are Carroll physicians.

1979 medical staff officers at the Floyd County Memorial Hospital are — **Dr. Gary Richardson**, president; **Dr. Conrad Frydenlund**, vice president; and **Dr. Roger Rademacher**, secretary. All are Charles City physicians. . . . **Dr. Russell H. Watt**, Marshalltown, has been elected to the board of directors of the Security Savings Bank. Dr. Watt is associated with the Wolfe Clinic. . . . **Dr. Jack Morgan**, Fairfield, was guest speaker at a recent meeting of the community's Wit and Wisdom Club. He told of his canoe adventure

to the Superior-Quetico Boundary Waters wilderness area of Minnesota and Canada. . . .

Dr. Donald C. Green was installed in January as president of Polk County Medical Society; **Dr. Lester Beachy**, president-elect; and **Dr. Lance E. Longnecker**, secretary-treasurer. All are Des Moines physicians. . . . **Dr. Francis Pisney**, formerly of Rapid City, South Dakota, has assumed the family practice of **Dr. Thomas Altemeier** in Iowa Falls. Dr. Pisney received the M.D. degree at U. of I. College of Medicine; he served a family practice residency at Muncie, Indiana. In 1974 he joined the National Health Service Corps, practicing in Martin, South Dakota; then spent a year in private practice in Red Oak, Iowa, and later located in Rapid City. Dr. Altemeier has been in Iowa Falls since 1976. He has accepted a teaching position in a family practice residency program. . . . **Dr. Ian M. Smith**, professor in Department of Internal Medicine at U. of I. College of Medicine, was guest speaker at a Symposium on Pneumonia sponsored by Finley and Xavier Hospitals and Mercy Health Center in Dubuque. Dr. Smith spoke on the treatment of pneumonia with emphasis on newer antibiotics.

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AIR FORCE. HEALTH CARE AT ITS BEST.

IPA's, Bed Numbers On President's Mind



Right now we have physicians in four different Iowa cities taking a look at alternate delivery systems (ADS). Of specific interest in these considerations of the ADS or health maintenance organization (HMO) concept is the individual practice association (IPA). We note in several instances these possibilities are being investigated cooperatively by county medical societies, hospital administration and others. We should mention also that business and industry have had a definite part in stimulating these explorations.

The Iowa Medical Society is following these developments and is supplying informational help when requested. Our Society policy supports the pluralistic approach to health care delivery. So this investigation of alternatives is appropriate. It's possible one IPA may be operating by the end of the year. We will keep you informed of these interesting developments.

Also, there's been a push by some health planners to put in place a new statewide formula to cover the number and use of Iowa's acute care beds. This new bed projection criteria — which has been suggested by the State Health Planning and Development Agency — is now being applied to each county to see how the numbers turn up. This is being done

on request of the Statewide Health Coordinating Council.

Just a year or so ago the Iowa Health Systems Agency compiled guidelines applicable to hospital bed determination. Now before the ink is dry, and we have had a chance to see if they will work, a new approach is being pressed. Let me assure you a hard look will be taken before we agree to any changes in the formula.

Let me remind you the IMS Scientific Session is June 18-20 at Tan-Tar-A Lodge on Lake of the Ozarks. Reservations are being received steadily from doctors throughout the state. It will be an excellent meeting with the opportunity for a good family vacation.

Finally, let me acknowledge this as the annual University Issue. We are fortunate to have excellent involvement by the College of Medicine in our Society activities.

A handwritten signature in cursive script that reads "Russ Gerard".

Russell S. Gerard, M.D.

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JOURNAL OF THE

Iowa medical society

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APRIL 1979

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Dean Lauds Choice Of New IMS President

In responding to Editor Neumann's request for a "message" to introduce the annual University Issue, it is always tempting to review the highlights of the past 12 months and perhaps to suggest a few College of Medicine accomplishments for which a complimentary word or two might be in order, if anyone were inclined to offer them.

This year, however, I must in all conscience extend the compliments to you for your choice of one of my close colleagues as 1979-80 president of the Iowa Medical Society.

In Paul Seebohm you have — as most of you so well know — an individual completely dedicated to first-rate performance, whether in practice or in teaching or in the laboratory, and certainly in contacts with patients and public.

Paul's grasp of the pressures on the profession, his knowledge of "what's out there" to help — and to hinder — the

practice of good medicine, and his instinct for finding the right combinations of people and resources to accomplish desired objectives, has made him an invaluable liaison between the educational effort and the complex world of practice, government, foundations, planners, communities, and countless other agencies and organizations.

Many of you, through the Society and through other professional involvements, have shared your knowledge and ideas with Dr. Seebohm for our benefit here on the campus. Now it is our turn to share him with you, which we are honored to do.

John W. Eckstein

John W. Eckstein, M.D.

1979 Administrative 'Front-liners'

GORDON STRAYER

Iowa City

This is a time of great expectations for medical education. At the U. of I. College of Medicine, a management team directs its energy at achieving these expectations. The team members are identified here.

FOR PHYSICIAN MEMBERS of the Iowa Medical Society who graduated from The University of Iowa College of Medicine a generation or more ago, memories of *The Dean's Office* are likely to reflect a sanctum only rarely entered, a formal atmosphere inhabited by one or two men in business suits, a couple secretaries — and Alice White, to whom the entire medical faculty, student body and a succession of deans looked for answers to questions of fact and procedure.

Miss White retired several years ago, thus requiring the College to develop a new data bank less dependent on one individual's memory. And today's generation of medical students is in and out of the Dean's Office more or less continually, to utilize a special student information center adjoining the office, and for informal contacts with staff members who are there specifically to help students cope.

These are only two of the more obvious differences in the administrative structure and function of the College as it exists today in comparison to the past. Because most members of the Iowa Medical Society have some contact with the College, and because IMS President-Elect Paul M. Seebohm is a key figure in its administration, the JOURNAL thought it

worthwhile and timely to present a brief profile of the current management team at the College.

Very briefly, its members are responsible for the long-range and day-to-day operations of the third largest college within the organizational framework of The University of Iowa. This element of the University:

- Enrolls 700 undergraduate medical students, 500 residents and fellows, and 50 physician's assistants;

- Teaches the basic medical sciences to many hundreds of additional students in dentistry, nursing, pharmacy, liberal arts, and the Graduate college;

- Has a faculty of 450;

- Carries out most of its clinical teaching in the nation's largest university-owned teaching hospital, University of Iowa Hospitals and Clinics;

- Is affiliated with 17 community and Veterans Administration hospitals throughout Iowa, and with several health care programs, for undergraduate clerkships and a nationally-recognized family practice residency program; and

- Is currently budgeted at \$63 million annually (more than the *total* University and Hospitals budgets just 15 years ago), of which nearly a third is earned by its own faculty members through patient care, nearly half represents grant, contract and gift earnings — and barely one-fourth comes from state appropriations and student tuitions.

As Dean of the College of Medicine, *John W. Eckstein, M.D.*, has overall responsibility for faculty recruitment and appointments, educational and research programs, admissions, placement and student affairs, budget making, fiscal management, interaction with the U. of I.

Mr. Strayer is Director, Health Center Information and Communication, The University of Iowa.



MANAGEMENT TEAM — Front-line members of the College of Medicine management team are (seated left to right) Assistant Dean for Veterans Administration Medical Center Affairs Richard D. Eckhardt, M.D.; Associate Dean for Medical Student Affairs and Curriculum George L. Baker, M.D.; Dean John W. Eckstein, M.D.; Assistant Dean for Administration and Finance William L. Lillibridge, M.A.; (standing left to right) Associate Dean Woodrow W. Morris, Ph.D.; Executive Associate Dean Paul M. Seebohm, M.D.; Associate Dean for Academic Affairs Rex Montgomery, Ph.D., D.Sc., and Associate Dean for Continuing Medical Education Richard M. Caplan, M.D.

administration, liaison with government agencies and national educational organizations, space utilization and equipment, and a variety of other activities which strengthen educational, research, and professional service functions of the College.

Dr. Eckstein represents the faculty of the College as spokesman and interpreter in relating to the other nine colleges of the University.

Executive Associate Dean *Paul M. Seebohm, M.D.*, represents the College of Medicine in a variety of capacities and places, beginning with clinical matters involving University Hospitals and Clinics and extending literally throughout the state via such programs as the Family Practice Network; state agencies such as the Department of Health and Board of Medical Examiners; planning bodies such as the Iowa Health Systems Agency, and professional organizations such as the Iowa Medical Society. In Dean Eckstein's absence, he serves as chief administrative officer for the College.

Associate Dean for Medical Student Affairs and Curriculum *George L. Baker, M.D.*, administers the medical student curriculum, admissions program, student aid and other support services for both medical and physician's

assistant students. He serves as liaison to medical student organizations and works with faculty who counsel students on personal and academic problems.

Associate Dean for Academic Affairs *Rex Montgomery, Ph.D., D.Sc.*, is concerned with the College of Medicine's undergraduate and graduate teaching programs, and with the relationships of these programs to other units of the University — particularly the three other health science colleges (Dentistry, Nursing, Pharmacy) and the Graduate College. Dean Montgomery also guides the development of various resources utilized in support of medical teaching and research, such as audiovisual, television and bioengineering services. And he represents the College in the development and implementation of various allied health programs.

Associate Dean for Continuing Medical Education *Richard M. Caplan, M.D.*, coordinates and provides support services for a continually growing number and variety of continuing education offerings. Dean Caplan plans many such courses in cooperation with other University of Iowa colleges and the Learning Resources Unit of the College of Medicine.

Associate Dean Woodrow W. Morris, Ph.D., coordinates the activities of pre-medical advisors in colleges throughout the state. In addition to supervising long-term evaluations of the medical curriculum, he designs tests which aid in predicting ultimate attributes and performance of Iowa medical graduates.

Assistant Dean for Veterans Administration Hospital Affairs Richard D. Eckhardt, M.D., relates to the clinical education and service programs of the Iowa City Veterans Administration Medical Center, where he is chief of staff. Medical staff members of the VA Hospital hold faculty appointments in the College of Medicine.

Assistant Dean for Administration and Finance William L. Lillibridge, M.A., is responsible for fiscal and budgetary matters, and he functions as business manager of the faculty Medical Service Plan.

These are the front-line members of the College of Medicine management team, each responsible for a variety of sub-functions within those cited above. It should not be inferred that lines are so sharply drawn as to mark out functional fiefdoms, each presided over by an associate or assistant dean — rather, these in-

dividuals necessarily operate as a team, with each providing capable assistance in other areas as the need arises.

"This is an age of great expectations for medical education," Dean Eckstein says, continuing: "Think for a moment of the expectations of the students, of their parents and families, of the profession, of the community, of the Regents, of state and federal legislators and health agencies, and of the general public. We live with these expectations, and we are trying to meet all of them which are compatible with our educational mission as a state university-based medical college. We are having to do this in a time of spiraling inflation, decreasing proportions of fiscal support from both our state and federal government, and continued competition for faculty.

"To meet even some of these expectations in these times requires the pooling of many skills by individuals completely dedicated to the quality education of young physicians. In all humility, this is what we have tried to achieve in structuring an office which can function and coordinate in the continually growing number of complexities surrounding medical education today."

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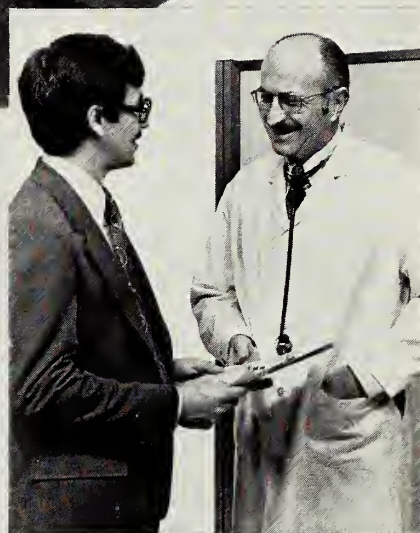
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Unveil Helicopter Service

Half the state's population will be within 30 minutes of University Hospitals beginning this month. A new Air-Care Emergency Helicopter Service will make this possible. It will be dispatched on call from community physicians and hospitals and law enforcement officials.

AN AIR-CARE EMERGENCY HELICOPTER SERVICE will begin this month at the University of Iowa Hospitals and Clinics. This program will further strengthen the Hospitals' statewide extension of tertiary-level emergency services to community physicians and hospitals.

The expansion of the helicopter service, formerly provided only by the Iowa National Guard, places 50% of the state's population within one-half hour of the Hospitals' Multispecialty Trauma and Emergency Treatment Center.

CRITICAL CARE TEAM & TECHNOLOGY ABOARD

An experienced critical care nurse, highly skilled in emergency and life support care, is aboard each flight. When indicated by the patient's medical condition, a physician accompanies the critical care nurse.

In addition to the clinical team, the helicopter is equipped with oxygen and suction, a portable defibrillator with heart monitoring capability, emergency drugs and supplies, splinting equipment, specially designed airlift stretchers, and other life support technology needed for the in-flight care of all types of emergency patients.

FAST RESPONSE

The *Air-Care* helicopter, based adjacent to University Hospitals' Multispecialty Trauma and Emergency Treatment Center, is airborne within five minutes after a request is received. The Aerospatiale AStar 350D jet-powered helicopter cruises at 150 mph. It is capable of carrying two patients, two clinical team members and the pilot over a 400-mile range without refueling.

GUIDE FOR REQUESTING AIR-CARE EMERGENCY HELICOPTER SERVICE

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Iowa City	(319) 353-6440

INFORMATION NEEDED

Patient's name (if possible)
Type and extent of injuries
Nearest landing site
Weather conditions
Nearby landmarks
Nearby highways or major streets
Name of person or agency requesting service and call-back numbers

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Iowa State Patrol
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Fire or police officer
Civil Defense worker
Industrial safety officer or nurse

COMMUNICATIONS

Ground-to-air communications link the *Air-Care* clinical team and pilot with the staff of University Hospitals' Emergency Treatment Center. The helicopter is also equipped for radio communications with other hospitals, ground ambulances and law enforcement vehicles and airports.

OTHER EMERGENCY PATIENT TRANSPORTATION SERVICES

To provide optimum flexibility in serving patients referred to University Hospitals by physicians in communities throughout the state, the *Air-Care* Emergency Helicopter is backed up by a new overland Mobile Critical Care Unit and the currently operating Neonatal Critical Care Van. Both emergency ground vehicles are fully equipped and staffed to provide emergency care for patients.

TERTIARY CARE EXTENDED

The *Air-Care* Emergency Helicopter Service extends the emergency medical services of The University of Iowa Hospitals and Clinics and reduces the time a critically ill or injured patient experiences before reaching tertiary-level services. The *Air-Care* helicopter and crew are on continuous alert for the transportation and care of emergency patients upon request of community physicians, hospitals and law enforcement officials.

Patients, under continuous monitoring by *Air-Care* critical care nurses, will be transported to U. of I. hospitals or any other appropriate site of care, at the direction of the patient's physician and in consideration of the patient's medical condition and available landing facilities.



Figure 1. The Aerospatiale AStar 350D jet-powered helicopter pictured here cruises at 150 mph. The *Air-Care* helicopter is based on a helipod adjacent to the Roy J. Corver Pavilion. It is able to transport two patients, two clinical team members and the pilot over 2,400-mile range without refueling. It puts half the state's population within 30 minutes of Iowa City.

Andreas Vesalius — Sixteenth Century Anatomist

RICHARD EIMAS

Iowa City

For medical history buffs, a visit to the John Martin Rare Book Room in the Health Sciences Library would be fascinating. The famous work of Vesalius, described here, is housed at The U. of I. Library.

ANDREAS VESALIUS was born in Brussels early in 1514. He came from a long line of physicians and, when of age, followed readily in the family tradition. His great-great-grandfather had translated the *Canon* of Avicenna and his son taught medicine at Louvain. Vesalius' grandfather was physician-in-ordinary to Mary of Burgundy and also wrote a commentary on Hippocrates' *Aphorisms*. Vesalius' father was court pharmacist to Emperor Charles V when Vesalius was born.

Vesalius received his medical education at Paris and later at Padua, where he became a member of the faculty while yet in his early twenties. As he matured and assumed the responsibilities of an academician, his interest in the structure and function of the human body often led him to cemeteries and places of execution where he could obtain the bodies needed for his teaching and research. As a result of his studies, he became discontented with the

then-prevalent reliance on the anatomical teachings of Galen (ca. 130-ca. 200) which were largely based on animal dissections. Vesalius had the courage to challenge Galen's authority and presented the results of his painstaking research in *De Humani Corporis Fabrica Libri Septem*³ (On the Structure of the Human Body) in 1543. This book is considered by many authorities to be the most famous anatomical work ever published and remains as one of the most beautifully illustrated anatomies ever printed. It was a masterpiece of care and accuracy, containing in text and visual form representations of the dissected human body parts.

REVOLUTIONIZED ANATOMY

Vesalius made many discoveries and so revolutionized anatomy that he remains as one of the truly great figures in medical history. His research on the vascular system was of extreme importance, and it was he who determined the position, form, and internal structure of the heart. (However, it remained for William Harvey (1578-1657) to explain satisfactorily the circulation nearly 100 years later.) Vesalius gave the first satisfactory description of the sphenoid bone and showed the sternum consists of three parts and the sacrum of five or six. He was the first to describe the omentum and its connection with the stomach, spleen, and colon. He also described accurately the mediastinum and pleura, the tensor tympani muscle, and the labyrinth and vestibule of the ear.

It was not long after *De Fabrica* appeared that the centuries-old authority of Galen arose to torment Vesalius in written and verbal attacks by the medical establishment of his day. One of

Mr. Eimas is Reference/History of Medicine Librarian at The University of Iowa Health Services Library.

the first criticisms came from his former teacher, Sylvius (1478-1555), who called upon him to admit his Galenic heresy. He was reproached for making mistakes, and it was true that he did make errors, but that was to be expected considering the scope of his work and the enormity of his subject. It may have been as a result of these attacks that he burned his manuscripts, abandoned his scientific and academic career, and left Padua in 1544. After having accomplished so much in his youth, he exchanged the intellectual life for the easier and more lucrative life of the court. He entered the service of the Spanish monarch, Charles V, and subsequently became physician-in-ordinary to King Philip II of Spain.

After many years at the Spanish court in Madrid, he undertook a journey to Jerusalem. The reason he took this trip is uncertain but there is a reasonable amount of evidence to show he may have made the journey as a penance to escape the heavy hand of the Inquisition. According to one story, he opened the chest of a dead nobleman during an autopsy only to find the heart still beating. He was brought before the Inquisition and was sentenced to death; only with difficulty was his sentence commuted to a pilgrimage at the intercession of Philip II. During his return from the Holy Land, he was planning to stop in Padua where he had been invited to reoccupy his old chair of anatomy, then vacant. How-



The John Martin Rare Book Room

The John Martin Rare Book Room in the University of Iowa Health Sciences Library houses one of the library's most valuable resources — a collection of rare books on the history of the health sciences with special emphasis on the history of medicine. The nucleus of the collection was given to the University by John Martin, M.D., of Clarinda, Iowa in 1971 and was moved into the Health Sciences Library when it opened in mid-1974.

Dr. Martin, an Illinois native, has M.D. and Ph.D. degrees from Northwestern University. He was an Army surgeon during World War II serving first in the Mediterranean theater and later as chief of the Department of Neurological Services at Walter Reed Army Hospital in Washington, D.C. He spent the years follow-

ing in the Chicago area, where he was a member of the Northwestern University Medical School faculty.

At the present time, Dr. Martin practices in semi-retirement in Clarinda where he is also on the medical staff of the Clarinda Municipal Hospital. He is a regular visitor to the University and remains active in the rare book field by continuing to purchase important works for the Rare Book Room.

Among the many rare and classic volumes in the collection are a large number on anatomy and surgery. The purpose of this article is to discuss one of the foremost figures in the history of medicine, a man whose anatomical works are among the most important ever written.

ever, he became ill during the return trip and died on the Island of Zante off the west coast of Greece in 1564.

Vesalius organized his epoch making *De Fabrica* into seven books: 1) bones and cartilages, 2) ligaments and muscles, 3) veins and arteries, 4) nerves, 5) organs of digestion and reproduction, 6) heart and lungs, and 7) brain and sense organs.

FIRST BOOK

In the first book, he treated the bones and cartilages with a thoroughness that amazed his contemporaries. He was the first author to correctly describe the skeletal system as a whole; often, as mentioned earlier, placing himself in direct opposition to the opinions of Galen. In all respects, he wrote more intelligently on the bones than any anatomist who preceded him.

The second book on the ligaments and muscles contained few errors and was far superior to any earlier work. His plates of the superficial muscles are among the most beautiful that have ever appeared and were copied in many later treatises on anatomy. The muscle figure

shown here appears in Book Two, with 13 other figures depicting various views of the human body.

The vascular system is described in the third book. Vesalius included two full-page woodcuts of the entire venous system and fully described and illustrated the arterial system. Numerous other plates showed the cerebral, portal, and pulmonary circulations. In the fourth book, Vesalius dealt with the nervous system. His illustrations of the nerves were very creditable. He mentioned 11 of the 12 pairs of cranial nerves and included an excellent woodcut of the recurrent laryngeal nerve.

The abdominal viscera were fully described and illustrated in the fifth book. Vesalius gave an admirable account of the peritoneum, mesentery, omentum, stomach and intestines, liver, spleen, and the genitourinary tract. In the sixth book, he presented the heart and lungs. His descriptions and illustrations of both were excellent. He described the heart's position, form, and structure in much better terms than previous anatomists.

ANATOMY OF BRAIN

The anatomy of the brain and sense organs were presented in the seventh book. His series of horizontal sections of the brain were very good and were among the earliest to appear in print. He described the pituitary gland but gave a poor account of the internal anatomy of the eye. He placed a spherically shaped lens in the center of the eye and felt it performed the functions we now ascribe to the retina. However, he did show the optic nerve was not a hollow tube as many of his contemporaries believed. It is interesting to note the final chapter of this book contains Vesalius' views on the dissection of living animals and their usefulness in studying anatomy.

Vesalius' *De Fabrica* went through four editions, two of which^{3, 4} were published during his lifetime. The library is fortunate to have all four editions of this famous work as well as excellent biographies of Vesalius.^{1, 2}

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The U. of I. Health Sciences Library was dedicated in 1974. It now houses 150,000 volumes with access to various other sources of scientific literature. The unique structure is contributing mightily to "a new era of excellence for the health sciences at Iowa."

WHILE CONSTRUCTION of the Health Sciences Library at The University of Iowa was under way, a critic complained it reminded him of a "ski slope for squirrels," because of the structure's many angles and sloping walls. At its dedication in 1974, the building was dubbed "the library that 2,000 people helped build." Nearly half of the funds for the \$4.2 million library came from alumni and faculty of the University's four health science colleges, professional organizations, practicing professionals, foundations, businesses and other friends of the University.

Chairman of a national committee that raised private funds was Donovan F. Ward, M.D., a Dubuque surgeon, a 1930 graduate of the College of Medicine, and a past president of the American Medical Association. Private support generated by the committee provided seed-money encouragement for a \$2.3 million grant from the federal Bureau of Health Manpower Education.

It is unlikely architect Walter Netsch, designer of the Health Sciences Library, was ruffled by the "ski slope for squirrels" chatter. Netsch was associated with the firm of Skidmore, Owings and Merrill of Chicago, whose work includes the controversial design of the

Air Force Academy Chapel. Netsch also was the architect for the College of Medicine's Basic Sciences Building and the University's Lindquist Center for Measurement.

In the Health Sciences Library, Netsch adapted a series of geometric units to fit on a small hillside west of Psychiatric Hospital and across the street north from General Hospital. Within the four levels of the building he has employed the so-called rotated square, the square, the octagon and the Greek cross in the design. The sloping walls and roofs, all poured concrete, often project at a 45-degree angle, creating many two-story open spaces inside. The interior has a broken floor plan and is highlighted by numerous skylights.



Figure 1. Study "nooks" such as this orio in the library have replaced the long study tables of the conventional library.



Figure 2. Main entrance to the library is just across the street north from the General Hospital.

GALLERIA

A "galleria" provides an enclosed passageway which allows pedestrians to enter at either the first or third levels of the building. Without entering the library portion of the building, students, faculty and staff can go through the galleria on their way to and from General Hospital and the Veterans Administration Medical Center. Many features of the building help to create a positive learning environment. For example, books on shelves serve as barriers to shield researchers from noise and other distractions. By utilizing open stacks in the central cores of the modules and placing study areas at the edges, a high degree of privacy is realized.

For those who remember the library facilities of yesteryear, the feature probably most admired is the new library's size — nearly 60,000 square feet, more than six times larger than the old medical library, which had been in use since 1927. The library houses the collections of the Colleges of Medicine, Dentistry, Pharmacy, Nursing, and the Department of Speech Pathology and Audiology. The facility seats 1,092 people compared with a combined seating capacity for 215 that existed in the previous health science library areas.

Unlike conventional libraries, there are no long lines of study tables where people sit

face-to-face. The variety of study areas include individual faculty study rooms; study carrels, either in individual or small, horseshoe-shaped units; group study rooms; seminar rooms; a typing room; lounge chairs and benches; audio-visual carrels; and a large conference room on level four. Currently, the library houses over 150,000 volumes, with a capacity of about 250,000 volumes. The old medical library had a capacity of about 60,000 volumes, with another 50,000 stored in other locations. A special area provides an atmosphere conducive to reading current journals, with display shelves for 400 of the 2,200 health science journals received by the library.

NATIONAL TIE-IN

Since it opened in 1974, the Health Sciences Library staff has greatly expanded its ability to tap the resources of the nation's storehouses of scientific literature. Computer-assisted literature searching began with the MEDLINE data bases, which cover journals indexed in *Index Medicus* for the fields of clinical medicine, medical research, biochemistry, virology, nutrition, and bioengineering. Now the Main Library and the Health Sciences Library offer on-line computer searching in the additional fields of biology, chemistry, psychology, education, physics, engineering, computer sci-

ence, and business management. Information obtained from the data bases is bibliographical in nature, consisting of author, title, journal or book citation, and often an abstract. If a user desires, a search strategy can be entered at the terminal and stored to be automatically processed each month.

As a participant in the Midwest Region Library Network, University Libraries can provide the literature search services at a nominal cost to users. Further information on computer searching can be obtained by writing the Health Sciences Library or calling 319/353-5382.

JOHN MARTIN ROOM

Far removed in time from the era of computers, a small area on the fourth level represents the "jewel" of the Health Sciences Library. It is the John Martin Rare Book Room, the repository for more than 1,200 volumes on the history of medicine — some dating back to the 15th century. Virtually the entire collection of rare books was donated to the library by John Martin, M.D., of Clarinda, a graduate of and a former faculty member at Northwestern University Medical School.

Dr. Leslie W. Dunlap, dean of library administration at the U of I, told the Fall meeting of the Council of the Friends of the University of Iowa Libraries that work is well under way on a revised and enlarged edition of *Heirs of Hippocrates*. The first edition of this bibliography on the holdings of the John Martin Rare Book Room was published in 1974 as a feature of the dedication of the Health Sciences Library. It is arranged chronologically by year of birth of the author and has biographical notes on authors as well as descriptive notes on their books. The first edition has 394 entries, while the 1979 edition will contain about 1,200 titles.

At the dedication ceremony which marked the first major change in health sciences library facilities at the University in nearly 50 years, Dr. Ward said: "At the campus nucleus, educationally and geographically, the new Health Sciences Library will offer its superior resources to students, faculty members, residents, interns, health science practitioners and others in a superb architectural setting. . . . With the consolidation of scattered facilities into one functional and beautiful location comes a new era of excellence for the health sciences at Iowa."



Figure 3. A conducive atmosphere for reading current journals is provided close to the main entrance to the library.



Figure 4. Examining one of the volumes in the John Martin Rare Book Room are Dr. Martin (left), Mrs. Willard Boyd, wife of the U. of I. president; and Donovan Word, Dubuque, who served as chairman of a national committee to raise private funds for construction of the library.

Legionnaires' Disease In Iowa: An Update

CHARLES M. HELMS, M.D., Ph.D.,
JOHN P. VINER, M.D.,
WALTER J. HIERHOLZER, JR., M.D.,
LAVERNE WINTERMEYER, M.D.,
EDWARD D. RENNER, Ph.D., and
WILLIAM JOHNSON, Ph.D.

LEGIONNAIRES' DISEASE (LD) is a newly-recognized respiratory infection of man which has most frequently manifested itself as a pneumonia. It has occurred both in epidemics and in isolated cases. The disease is caused by a fastidious small gram-negative bacterium recently named *Legionella pneumophila*. Since recognition of LD in July, 1976 over 1,000 epidemic and sporadic cases have been identified in the United States, Great Britain, Europe and Australia. The earliest case recognized, thus far, occurred in 1947. LD is, therefore, neither new nor geographically limited.

LEGIONNAIRES' DISEASE IN IOWA

Forty-one confirmed and 21 probable cases of LD have been identified in Iowa in the 12

Drs. Helms, Viner and Hierholzer, Jr., are associated with The U. of I. Department of Internal Medicine, Dr. Renner is with the University Hygienic Laboratory, and Dr. Johnson is with the Department of Microbiology at The University of Iowa. Dr. Wintermeyer is with the Iowa State Department of Health.

As many as 63 cases of Legionnaires' Disease may have occurred in Iowa since 1970. Notification by Iowa physicians is requested when suspect cases are observed. A state-wide cooperative study may shed important light on this newly-recognized disease.

months since laboratory diagnostic techniques have become available at the University of Iowa Hygienic Laboratory. These cases date back as far as July, 1970 and are shown by county of residence in Figure 1. Cases have resided in 29 of Iowa's 99 counties indicating that the disease is relatively widespread.

In 1978 at least 26 *L. pneumophila* infections were documented in Iowa for a minimum annual incidence of 0.9 cases per 100,000 population. This would suggest that LD is far less common than pneumococcal pneumonia, for example, which occurs with an incidence of 100 cases per 100,000 population per year. From retrospective studies, however, we estimate that *L. pneumophila* infections have accounted for 3-9% of the "atypical" or "viral" pneumonias which occurred between 1971 and 1978 and were reported to the University Hygienic Laboratory. Therefore, LD is not rare.

Although cases of LD have occurred in most months of the year, 76% of the cases clustered in the summer and early fall months as shown

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE
AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF APRIL 1979.

in Figure 2. Indeed preliminary data would suggest that 18% of atypical pneumonias presenting in the month of July in the years 1972-1978 were associated with *L. pneumophila* infection.

There is evidence that LD is not always a severe illness. The background rate of significant *L. pneumophila* antibody titers ($\geq 1:256$) is approximately 6% in several Iowa populations including previously healthy individuals without histories of pneumonia. If such high titers of antibody are specific for *L. pneumophila*, then some *L. pneumophila* infections may be quite mild or perhaps even asymptomatic.

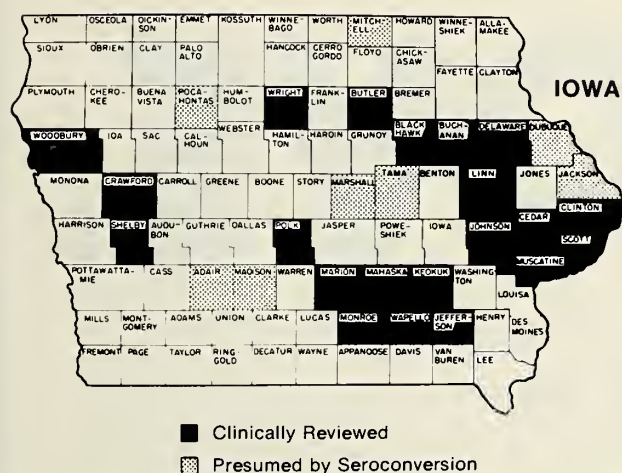


Figure 1. 62 cases of *Legionella pneumophila* infection by home county, July, 1970-December, 1978.

Of 41 reviewed cases from Iowa, all have been pneumonias. The male to female ratio is 2.9:1. The median age has been 51 years. Eighty-six per cent have smoked cigarettes. Thirty-six per cent have been compromised hosts with underlying medical disorders. The case-fatality rate has been 36%, but we believe this rate is spuriously elevated above the national average of 16% since our search has focused on fatal pneumonias.

Sporadic LD is difficult to differentiate clinically from other causes of pneumonia. In Iowa, summertime pneumonias of unclear etiology occurring in middle-aged individuals should be particularly suspect. Progressive pneumonias, severe atypical pneumonias and pneumonias occurring in association with unexplained encephalopathy or abnormal hepatic or renal function tests should also be suspect. It must be emphasized that the diagnosis of LD is now partially one of exclusion, *i.e.*, other

Intensive LD Surveillance in Iowa

Since September, 1978, LD has been designated as a reportable disease in Iowa and in the United States by the State and Territorial Epidemiologists and the Center for Disease Control. Beginning in the spring of 1978, a cooperative investigation of LD in Iowa has been underway. This is through the joint efforts of the University Hygienic Laboratory, the Infectious Disease Division of the Department of Internal Medicine and the Program of Epidemiology at the University of Iowa Hospitals and Clinics, the Department of Microbiology of the University of Iowa College of Medicine, and the Iowa State Department of Health. The initial findings of this group were presented at the First International Symposium on Legionnaires' Disease, held in Atlanta, Georgia in November, 1978.

common causes of pneumonia must be ruled out by appropriate standard laboratory tests such as the sputum gram stain and sputum and blood cultures. Specific laboratory diagnostic tests for *L. pneumophila* infection are available through the University Hygienic Laboratory.

The cooperative study group is interested in assisting Iowa physicians in the investigation and confirmation of all suspected cases of Le-

(Please turn to page 154)

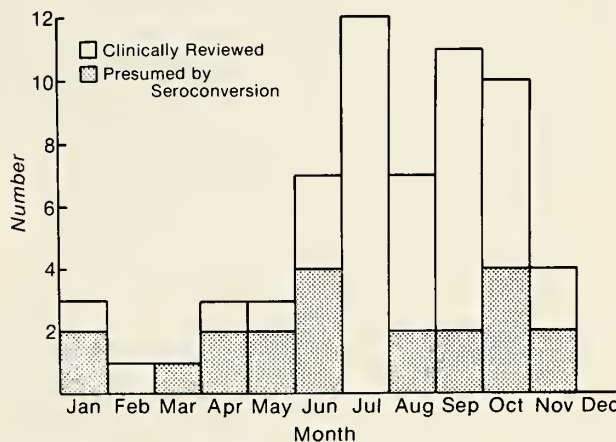


Figure 2. Cases of *Legionella pneumophila* infection by month of onset, July, 1970-December, 1978.

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The Visiting Professor Program: Enriching the Educational Environment

LOU CRIST, B.A., and
ROGER TRACY, M.A.
Iowa City

IN A RESPONSE to the shortage of family doctors, the 1973 Iowa General Assembly enacted a statute which created the Statewide Medical Education System. This is also referred to as the Statewide Family Practice Training Program. The statute gave The University of Iowa College of Medicine responsibility for developing and coordinating the statewide program. Among the goals of the Statewide Family Practice Training Program are:

- *To provide educational support through the College of Medicine to faculty of the community-based training programs.*

- *To enrich the educational environment of regions where graduate training programs are located – making such areas attractive places for physicians of all specialties to practice.*

Through a state appropriation, the College of Medicine provides support to all programs in the Statewide Medical Education System. Seven of the programs are affiliated with The University of Iowa and receive direct educational support in addition to the financial backing. The University affiliates are located in Des Moines, Davenport, Mason City, Sioux

U. of I. faculty travel regularly to Family Practice Training sites to supplement and enhance local teaching efforts. The VPP is regarded as mutually rewarding and deserving of continuation.

City, Waterloo and Iowa City. Programs at Cedar Rapids and Des Moines General Hospital are not affiliated with the University, but receive indirect educational support through special grants from the family practice appropriation.

TWO-FOLD PURPOSE

An important source of educational support for the University-affiliated programs has been the College's Visiting Professor Program (VPP). Visits by the College of Medicine faculty serve a two-fold purpose: (1) they contribute to the basic training experiences of family practice residents, and (2) the teaching visits provide a source of continuing medical education for physicians in the areas surrounding the training programs. Figure 1 shows the growth of College-sponsored visiting professor activities and a corresponding increase in the number of University-affiliated programs during the same period.

The VPP has a variety of educational aspects. Most visits include a presentation by the faculty member to that hospital medical staff which sponsors the residency program. This is open to other physicians in that particular community and from the surrounding region, plus interested allied health professionals. The visiting professor also presents a didactic con-

Mr. Crist is associated with the College of Medicine Office of Continuing Medical Education. Mr. Tracy serves as coordinator of the College's Office of Community-Based Programs. The Visiting Professor Program is coordinated by the Office of Continuing Medical Education, Richard M. Caplan, M.D., Associate Dean for Continuing Medical Education.



Following a lunch hour presentation as a visiting professor at St. Luke's Hospital in Davenport, Dr. Charles Hawtrey (right), U. of I. professor of urology, discusses patient problems with family practice residents (from left) Drs. Steve Lewis, Steve Smith, and Lorry Severidt. Dr. Howtrey continued consultations with residents later at the Family Practice Center.

ference for the teaching service appropriate to his area of expertise. As an added dimension of the conference, family practice residents may give case presentations which are followed by comments and suggestions from the faculty member.

The format varies from program to program. Other visiting professor activities may include teaching rounds, informal discussion with medical staff members and formal consultation at a hospital or family practice center. Informal consultation may be approximately a half-hour in length before which physicians are informed that the visitor will be available to them. The consultations at the family practice centers al-

ways include family practice residents and may include their patients.

If the meeting of a county medical society coincides with the visit of the faculty member, he/she may serve as its speaker. Less common, but not uncommon, are chart audits at a hospital, family practice center or physician's office; and patient/family education sessions. Rather than just one or two activities, College of Medicine faculty generally prefer visits that include a variety of teaching activities.

REQUESTS

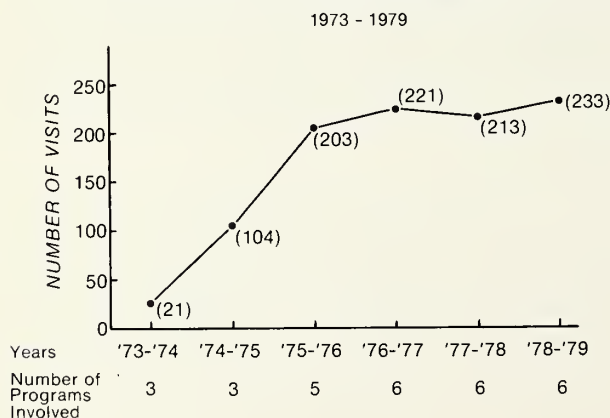
Requests (date, topic area, and in some cases, particular faculty member) are submitted to the Office of Continuing Medical Education by each residency program director. With few exceptions, the requests are filled and visits are confirmed through cooperative effort of the specific department and the Office of Continuing Medical Education. There has been good participation in the VPP by all academic and clinical departments within the College of Medicine and University Hospitals and Clinics.

By prior arrangement, educational activities of the VPP at all training sites meet the requirements necessary for participating physicians to acquire Category 1 credit toward the American Medical Association's Physician's Recognition Award.

ACHIEVEMENTS

In July, 1979, the Family Practice Residency Programs, the College of Medicine and its departments begin their seventh year of formal visiting professor activities. As is true with any worthwhile effort, the residency program directors, their residents and staffs, along with the College of Medicine personnel involved in the VPP spend considerable time evaluating its effectiveness and looking for ways to improve this valuable activity. Largely because of this, the VPP has been successful in enhancing the educational experiences available to family practice residents and clinical faculty in the community-based training programs. It has stimulated development of CME for practicing physicians and other health professionals at the community level. And lastly, the Visiting Professor Program helps maintain the close relations existing between the University Health Center and referring physicians across the state.

Figure 1 - GROWTH IN VISITING PROFESSOR ACTIVITIES



Who and Where Are Iowa PA's

Denis R. Oliver, Ph.D.,
Douglas W. Laube, M.D.,
Gary Johnson, B.S., P.A.-C., and
Janet Steenlage, B.A.
Iowa City

Presented here are facts which characterize the 90 graduates of the Iowa PA program. Their backgrounds and the current job locations are reviewed.

THE UNIVERSITY OF IOWA College of Medicine Physician's Assistant Program admitted its first class of 10 students in 1972. Since then the program has graduated 90 PA's with an additional 24 students finishing in May, 1979. Previous publications in this JOURNAL have discussed the Iowa PA program curriculum¹ and the distribution of PA's in the state.² This article is to present data on the biographical characteristics of students who have been accepted into the Iowa PA Program over the past 7 years as well as provide an update on curriculum changes and the distribution pattern of program graduates.

THE ENTERING STUDENT

The data reported in Tables 1 and 2 were obtained by averaging across the 7 entering classes from 1972 through 1978. One hundred and forty-four students have been accepted into the Iowa PA Program over this period. Competition for places in the program is very intense with approximately seven to eight ap-

plicants for every available position. The class size ranges from 20-25 per year. The average age of the entering student is 25 years with a range between 19 and 43. The percent of women in each class is 43%, ranging from a low of 30% (1974) to a high of 68% (1977). Preference is given to those applicants who are Iowa residents and is reflected in Table 1 (76% Iowa residents vs. 24% non-residents).

Graduates of the Iowa Physician's Assistant Program receive a bachelor of science degree from the College of Medicine upon successful completion of University and program requirements. The minimum prerequisites for entry into the program include completion of a minimum 60 semester hours (s.h.) of college level work. Three quarters (71%) of the entering class have already earned a baccalaureate degree or higher, typically with majors in biology, chemistry or zoology (Table 1). Although on the average, 26% of the entering class do not have a college degree, the mean number of college credits completed is 129 s.h. which is comparable to the number of semester hours required for a baccalaureate degree. The PA program science course requirements include at a minimum the completion of inorganic and organic chemistry, introductory biology/zoology, and advanced courses in biology/zoology. The mean number of science credits completed by the entering class is 54 (s.h.) which is usually distributed in the following way: biology (24 s.h.), chemistry (14 s.h.), math (8 s.h.), physics (8 s.h.).

The science and cumulative grade-point average (g.p.a.) have remained stable at the 3.0-3.1 ($A = 4.0$). The minimum g.p.a. for acceptance is 2.5.

Most physician's assistant programs in the country, including Iowa, require previous health care experience preferably with considerable patient contact.

Dr. Oliver is Director of the Physician's Assistant Program and associate in biochemistry at the University of Iowa College of Medicine. Dr. Laube is Medical Director, and assistant professor of obstetrics and gynecology. Gary Johnson is Clinical Coordinator, and Janet Steenlage is Program Assistant of the Physician's Assistant Program.

The mean length of health care experience completed prior to entry into the Iowa program is 29.6 months (Table 2). This health related experience is acquired in a variety of meaningful ways ranging from working as a nurse's aide and orderly to emergency medical technician and nurse. For those who have completed college level training in a health related area, such as medical technology or nursing, the primary reason cited for returning to school for additional training in the physician's assistant program is to become more involved with the direct medical management of patients. It would appear that students with previous health care experience are more able to visualize the future dependent role of the physician's assistant in the health care delivery system.

PRIMARY CARE ORIENTATION

The Iowa PA program is two years in length and is divided into three phases. During Phases I and II (first year) the student receives instruction in the basic medical sciences and a comprehensive introduction to clinical medicine (with the sophomore medical students), respectively. Phase III consists of one year of supervised rotations in required and elective specialties, including: Family Practice (12 weeks), Internal Medicine (6 weeks), Pediatrics (6 weeks), Ob/Gyn (6 weeks), Surgery (6 weeks), Psychiatry (4 weeks), and electives (8 weeks).

The goal of the Iowa program is to train individuals to function effectively and responsibly

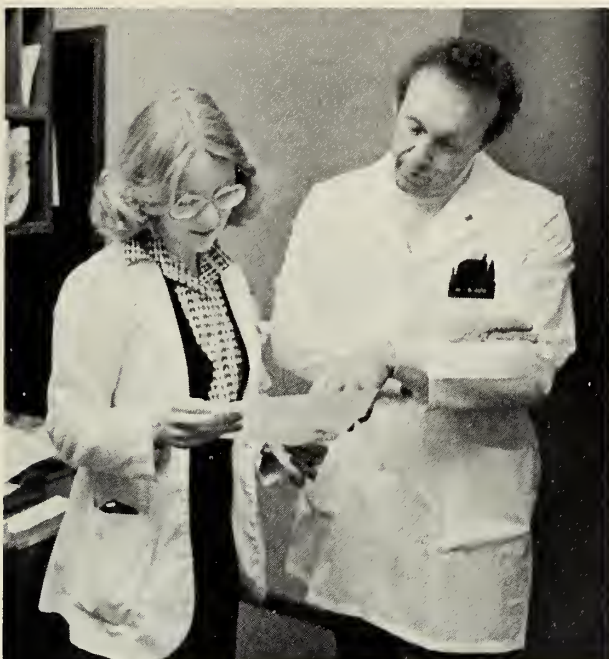
as assistants to the primary care physician. The educational curriculum is designed to provide graduates the knowledge and ability to perform a wide range of tasks of health care management and education commonly encountered in a primary care setting. This is reflected in the requirement that 12 weeks or 25% of the clinical year is devoted to training in family practice specifically.

PROJECT INITIATED IN 1977

With this goal in mind, the Physician's Assistant Program applied for and was awarded a three-year grant from the Department of Health, Education, and Welfare to interface PA training with residents in family medicine. The project was initiated in July, 1977 and has enabled the PA program (a) to provide for the employment of a graduate PA and (b) to develop a program for training senior PA students at each of three Family Practice Residency Training sites in Mason City, Davenport (DeWitt and Lowden) and Broadlawns Polk County Hospital in Des Moines. These clinical settings represent model family medical centers ranging from a large urban hospital (Des Moines) to rural satellite clinics (Lowden and DeWitt). The major objective of the project is to (a) demonstrate to the PA student the professional role of the PA as a dependent practitioner; (b) provide family practice residents the opportunity to work with both graduate and student PA's in a clinical setting to foster an appreciation for the capabilities and utilization of the PA, and (c) encourage the sub-

TABLE 1
BIOGRAPHICAL INFORMATION CONCERNING STUDENTS ACCEPTED INTO THE IOWA PA PROGRAM

Average class size: 21 Range: (10-26)			
Enrollment by sex, age and residency status:			
Age	Sex	Residency	
Mean: 25.1 years	Male: 57%	Residents of Iowa:	76%
Range: 19-43 years	Female: 43%	Non-residents:	24%
	Range: (30-68%)		
Educational background prior to entry into the program:			
College degrees attained:			
B.A./B.S. = 65%	A.A./A.S. = 3%		
M.A./M.S. = 6%	None = 26%		
Mean number college credits completed:	129.3 semester hours		
Mean cumulative g.p.a. (A = 4.0):	3.03		
Mean number science credits completed:	53.5 semester hours		
Mean science g.p.a. (A = 4.0):	3.0		



At the Davenport Family Practice Center, Physician's Assistant student Jonet Merrimon consults with Dr. Forrest W. Smith, director of the Family Practice Residency Program.

sequent association of these two professional groups in an interdisciplinary approach to the practice of family medicine.

An extensive evaluation of the project has been initiated and includes an analysis of the family practice residents' perception of the PA profession, particularly the PA's clinical role. Results from this evaluation will be forthcoming.

U. OF I. GRADUATES

As of May, 1978, the PA Program at the University of Iowa has graduated 90 persons. Upon graduation from an AMA approved program, graduate physician's assistants may sit for the National Certifying Examination for Primary Care Physician's Assistants administered by the National Commission on Certification of Physician Assistants under contract from the National Board of Medical Examiners. The exam was first given in 1973 and to date over 6,000 have successfully passed and are identified as Physician's Assistant-Certified (P.A.-C). All of the Iowa PA program graduates have successfully passed the two-day National Certifying Examination and have done so with notable success. Table 3 shows the number of PA training programs and eligible candidates sitting for the examination over a 5 year period, in addition to the mean

standard scores of all programs and the rank of the Iowa program specifically. Successful completion of the National Examination is required for PA registration with the Iowa State Board of Medical Examiners.

Table 4 summarizes the present location of these graduates by state. Sixty-six per cent of the graduates have remained in Iowa where all but 4 are currently employed as physician's assistants, one of whom is completing requirements for the D.D.S. from the U. of I. College of Dentistry.

TABLE 2
HEALTH RELATED WORK EXPERIENCE OF STUDENTS ACCEPTED INTO
THE IOWA PA PROGRAM

Mean length of health care experience: 29.6 months

Range: 3 months-10 years

Categories:

Nurse's aide/assistant	28%
Orderly	18%
Carpenter/medic	12%
Medical technologist	8%
Former medical technologist	6%
Nurse (RN)	5%
Surgery technologist	3%
Other	20%

TABLE 3
RESULTS OF THE NATIONAL CERTIFYING EXAMINATION FOR PRIMARY
CARE PHYSICIAN'S ASSISTANTS (1974-78)

	1974	1975	1976	1977	1978
Total number of programs represented	51	52	55	55	57
Total number of Candidates examined	1,303	1,411	1,615	1,639	1,650
Iowa graduates	10	22	18	24	21
Mean standard score:					
Other programs	490	481	483	479	469
Iowa PA program	561	555	557	570	543
Relative rank (from the top)	4th	3rd	2nd	2nd	4th

TABLE 4
LOCATION OF GRADUATES OF THE PHYSICIAN'S ASSISTANT
PROGRAM AT IOWA BY STATE

California	5	Minnesota	1	South Dakota	3
Colorado	2	Missouri	1	Utah	1
Illinois	3	Nebraska	2	Washington	1
Indiana	1	New Mexico	1	Texas	1
Iowa	59	New York	1	Wisconsin	2
Massachusetts	1	Oklahoma	1	Honduras	
Michigan	1	Pennsylvania	2	Central America	1
				Total	90

Figure 1 shows the geographic distribution of Iowa graduates employed as physician's assistants. This figure demonstrates the widespread distribution of the graduates, many of whom are situated in small rural Iowa communities. There is a concentration of PA's in both Des Moines (7) and Iowa City (14) where the primary employers are the VA Medical Center and Broadlawns County Hospital in Des Moines and the University of Iowa Hospitals and Clinics and VA Medical Center in Iowa City.

TABLE 5
LOCATION OF PHYSICIAN'S ASSISTANTS BY TYPE
OF PRACTICE SETTING

Office Practice Setting	
Solo	16
Partnership	13
Group — single specialty	14
Group — multi specialty	10
Total employed in an office setting	53
Institutional Setting	
State institution	10
Federal institution	6
City/county institution	6
Private institution	2
Total employed in an institutional setting	24

TABLE 6
LOCATION OF PHYSICIAN'S ASSISTANTS EMPLOYED IN OFFICE
SETTINGS BY COMMUNITY POPULATION

Community Size	Number	(%)
5,000 or under	21	(40)
5,000-10,000	7	(13)
10,000-20,000	3	(5)
20,000-40,000	7	(13)
40,000-60,000	2	(4)
60,000-100,000	4	(8)
Over 100,000	9	(17)
Total	53	(100)

TABLE 7
TYPE OF PHYSICIAN EMPLOYER BY OFFICE PRACTICE SETTING AND
SPECIALTY

	Partnership & Group			Total
	Solo Practice	(Single Specialty)	Multi- Specialty	
Family practice	16	19	8	43 (80%)
Internal medicine	0	3	0	3 (6%)
Ob/Gyn	0	3	0	3 (6%)
Surgery	0	2	1	3 (6%)
Pediatrics	0	0	1	1 (2%)
Total	16	27	10	53 (100%)

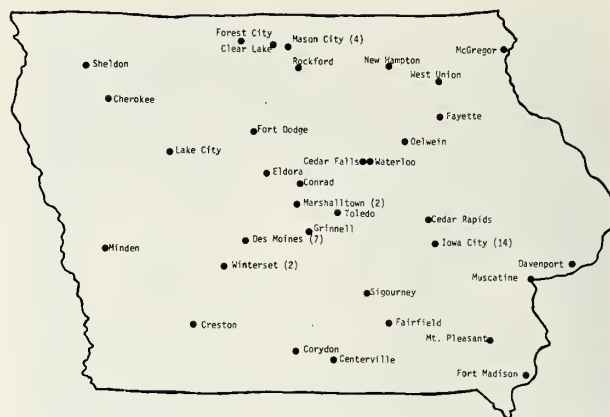


Figure 1. Geographical distribution of physician's assistants: Iowa graduates.

This urban concentration accounts for the number of PA's employed in an institutional setting (31%) as opposed to an office practice (69%) as shown in Table 5. This may reflect the fact that a relatively large number of clinical rotations during the second year of training are completed at these institutions — thus increasing the exposure to the staff at these facilities of the capabilities of this type of health care professional and enabling the student PA to learn of potential employment opportunities.

Table 6 shows the distribution of Iowa graduates employed in an office setting with respect to community population. Seventy-one per cent of the PA's are employed in communities with a population less than 40,000 and 53% are in communities of 10,000 or less. A major goal of the Iowa PA program is to train persons to assume a high degree of responsibility in primary health care delivery under the physician's direction and supervision and to deploy these individuals to areas of greatest need. On the basis of the current deployment pattern (Figure 1 and Table 6) a significant number of Iowa PA program graduates are located in rural communities where it may be conjectured there is the greatest need.

Table 7 shows that a majority of the PA's employed in an office practice setting are in family (general) medicine (60%). They are employed predominantly by physicians in group practices although a significant proportion are associated with the solo practitioner. Physicians in specialties such as obstetrics/

(Please turn to page 153)

First to Complete IM Residency

This report, excerpted from a longer report prepared for the Dean of The University of Iowa College of Medicine, describes the establishment of the General Internal Medicine Residency Program at Iowa Methodist Medical Center and the Veterans Administration Medical Center in Des Moines.*

THIS JULY, Drs. Sean Cunningham, Alda Knight, Ruth Langstraat and John Rachow will complete their training in the pioneer class of a new residency program in General Internal Medicine at the Iowa Methodist Medical Center (IMMC) and Veterans Administration Hospitals in Des Moines. The program is affiliated with The University of Iowa College of Medicine and University Hospitals. These physicians will be equipped to practice as primary or secondary internists by virtue of their training by both subspecialty and general internists.

A unique aspect of the residency is the close house staff association throughout the program with family practice trainees at the VA and IMMC. This association is designed to benefit both types of trainees by fostering a better understanding of the strengths and limitations of the two disciplines, and it should make the graduates of this residency particularly well suited for group practice with family practitioners.

* The report to the Dean of the College of Medicine was prepared by John S. Thompson, M.D., Affiliate Director of the Residency and Vice Chairman, Department of Internal Medicine, The University of Iowa; David T. Kaung, Associate Director of the Residency and Chief, Medical Service, Veterans Administration Medical Center, Des Moines; Catherine J. Condon, M.D.; Robert C. Smith, M.D.; and Nathaniel Josephson, M.D., Director of the Residency and Director of Internal Medicine Training, Iowa Methodist Medical Center. Associated with the program at the time the paper was written, Drs. Condon and Smith have since assumed new professional responsibilities in Harlingen, Tex., and Rochester, N. Y., respectively.

WELL GROUNDED

Another association that also may prove to be an asset for either solo or group practice is the opportunity during the VA rotations to work with certified physician's assistants and to help supervise PA trainees on rotation from the U. of I. Of most importance, the residents have been well grounded in the specialties of internal medicine by a full time faculty. They also have had extensive experience in the practice of general internal medicine. At least one-third of their training is provided by practicing internists.

While the three-year program was inaugurated with five residents in 1976, the first-year class was increased to nine in 1977 and, when fully developed, there will be a total of 27 residents in training. Physicians matched for the residency program have been predominantly, but not exclusively, graduates of the U. of I. College of Medicine. The quality of the group attests to an initial contention that the residency in Des Moines would be an alternative and not a substitute to the U. of I. programs.

Establishment of the residency program in General Internal Medicine in Des Moines resulted not by chance, but from a coalescence of ideas and events taking shape since at least 1972, and which perhaps could be dated to a remarkable thrust in medical education that occurred in Des Moines in 1946. In that year Iowa Methodist Hospital embarked on residency programs in surgery and pediatrics, and the Veterans Administration Hospital initiated a residency in internal medicine that was affiliated with the College of Medicine.

When the Veterans Administration Hospital was built in Iowa City, the attention of the

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College of Medicine naturally turned to its local neighbor and the internal medicine residency in Des Moines was discontinued in the early sixties. While a long hiatus followed, it was not a period of inactivity and by 1969 discussions were held regarding the desirability of increasing undergraduate and graduate medical training in Des Moines.

Continuing discussions, reviews of needs and assets, and planning details provided a number of challenges to the ingenuity of the professional and administrative staffs before this union of federal, state, and community institutions began to forge a basic structure for the new Des Moines residency program. By July, 1975, a proposal had been drawn up. It emphasized several critical factors, which are still germane, concerning the need for the program.

First, it was recognized that many Iowa communities needed physicians who had in-depth training in the diagnosis and treatment of both relatively simple, and serious, complex medical diseases. Although the internal medicine residency program at the University was expanding and renewed interest was being given to training the general internist, it was evident that even more graduates would be necessary to meet the state's needs.

Secondly, the medical class at the U. of I. was being increased to 175 entering students each year and it was evident that nearly all inpatient medical beds at University Hospitals would be utilized for the required junior clerkships, eliminating the opportunities for senior students to elect general medical ward training. Thus, a second aim of the proposed residency

program in Des Moines was to create an educational milieu that would also support medical electives for senior students.

CONCEIVED

Finally, the residency was conceived as an independent, but closely allied, component of the Department of Medicine's overall program for residency training. It would not be a substitute, but an alternative offering more opportunities in primary care and for close interaction with physicians in private practice. In addition, it was believed the large number of patients using the Des Moines Veterans Administration Hospital for both their primary and secondary levels of medical care would provide a unique opportunity for house staff training in long term continuous care of a group of patients.

From the fall of 1975, when an application for accreditation was made to the Liaison Committee on Graduate Medical Education, to the beginning of training for the first residents in July, 1976, represents a remarkably short "transit time" for this kind of collective endeavor. Credit for this goes to the solid groundwork that has been laid by many individuals representing all three institutions.

The internists who complete their residency training this July mark the first installment on a commitment to provide more general internists for Iowa. Much of the ultimate value and success of the program will not be known, of course, until the placement and achievement of several classes can be analyzed. In the interim, comments and questions regarding any aspect of the residency program are welcome.

WHO AND WHERE ARE IOWA PA'S

(Continued from page 150)

gynecology, pediatrics, general surgery and internal medicine are also employing PA's.

SUMMARY

In summary, the student entering the Iowa PA Program has completed extensive course work in the liberal arts and sciences as well as completing over two years of health related job experience. The training program is rigorous

and specifically oriented toward primary care medicine. Graduates have established national recognition for the Program through their excellent performance on the National Certifying Examination. A majority of the graduates have remained in Iowa and are employed predominantly in an office practice setting in communities with relatively small populations.

Twenty-four students will graduate from the U. of I. PA Program on May 18, 1979. Our Program Office will be pleased to assist any physician in the employment of one of our graduates; for information call 319/353-5711.

LEGIONNAIRES' DISEASE IN IOWA: AN UPDATE

(Continued from page 142)

gionnaires' disease. The criteria for identifying suspect LD cases are: 1) the acute onset of pneumonia, 2) fever greater than 38.3°C (101°F), 3) chest radiograph showing an infiltrate and 4) one or more of the following:

- a. disorientation, delirium, stupor or coma
- b. hematuria or renal failure
- c. abnormal liver function tests
- d. multilobar or bilateral pneumonia or progression of pneumonia on x-ray

Cases which have another bacterial pathogen in the blood, cerebrospinal fluid, or lung aspirate may be excluded.

NOTIFICATION

If you have a patient who meets these criteria, please notify the office of the State Epidemiologist, Laverne Wintermeyer, M.D., through the toll-free number, 1-800-362-2736. Your infection control practitioner can make this notification for you. Clinical consultation is available through Charles Helms, M.D., Ph.D., the Division of Infectious Disease of the Department of Internal Medicine, University of Iowa Hospitals, 319/356-1773. Submission of acute and convalescent sera and biologic material, if available, to Edward Renner, Ph.D., University Hygienic Laboratory, Iowa City, 319/353-5990, will be requested. Regional investigators of the State Department of Health are available for the collection of specimens of patients discharged from the hospital.

When the diagnosis of Legionnaires' disease is confirmed by serological or microbiological techniques, a follow-up questionnaire, developed by the Center for Disease Control, will be forwarded to the responsible physician. The nurse epidemiologist may complete and return this form to the State Department of Health under the physician's direction.

On the basis of information already available, it would appear that LD is not a rare event in Iowa. We feel a continuing investigation of it through this cooperative endeavor will shed important light on the clinical features, epidemiology and therapy of this newly-recognized disease.

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"Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated; avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncopal reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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Editorials

M. E. ALBERTS, M.D., Scientific Editor

TOWN AND GOWN

It has become a tradition for the April issue of the JOURNAL to be dedicated to the University of Iowa College of Medicine. Much has been said through the years about relations between practicing physicians in the towns and cities and their academic colleagues — the “town and gown.” In recent years, through efforts of the College of Medicine to provide continuing medical education, many differences of thought and action have diminished.

That complete harmony exists between the two areas is perhaps an overstatement, for there are some in the far-flung areas of the state who believe academia still has a “holier-than-thou” attitude, and there are professors who cannot comprehend the trials and tribulations of the often-lonely practitioner doing his best

under conditions not as heavily backed by extensive laboratory facilities and super-specialists who are available at a moment's notice. Yet, that problem exists to a lesser extent than a number of years ago.

Our Iowa Medical Society has a close relationship with the College of Medicine. Many of the medical faculty have been active in the labors of the Society, and a good number has held positions of leadership. Several faculty have served as Society Presidents (N. G. Alcock, M.D., 1950; E. F. Van Epps, M.D., 1961; and Rubin H. Flocks, M.D., 1974).

This year another professor assumes the presidency. We wish Doctor Paul Seeböhm joy and success in his year at the helm. An even closer communion is bound to develop between the College and Iowa practitioners as a result of his service. — M.E.A.

A DECADE OF PROGRESS

February 8 marked the tenth anniversary of the American Board of Family Practice (A.B.F.P.). On that date in 1969, the ABFP was approved by the AMA Council on Medical Education and the American Board of Medical Specialists. Within one month of that sanction, 1,690 physicians passed the first certifying examination. Now there are 19,144 diplomates.

The ABFP is the first specialty board to have mandatory recertification (by examination) every six years. They had no “grandfather”

provisions for certification; all are required to pass the prescribed examination to become a diplomate.

The family physician serves the entire family in the tradition of American medicine, providing a continuum of comprehensive health care without the confusion and fragmentation of super-specialist medicine. In Iowa there are approximately 1,100 family practitioners, of whom 104 were certified as of July, 1978. This is a good percentage of the total 2,774 members of the IMS. We have good family practice training programs in Iowa. Nationally, more than 6,000 physicians are involved in 3-year family prac-

(Continued on page 156)

EDITORIALS CONTINUED

tice training programs. In Iowa, we have approximately 175 physicians in the eight family practice residency programs.

This truly has been a decade of medical progress. We salute the family practitioner. Through earnest and dedicated efforts these physicians have raised the standards of medical practice. We salute their desire to be more proficient. — M.E.A.

PAUL O'KEEFE/1899-1979

On February 7, 1979, Paul O'Keefe, M.D., died from a long standing illness. He practiced medicine in Black Hawk County and Waterloo from 1926, except for the years he served in the Army in Europe during World War II. Dr. O'Keefe was in family practice and served for years as Black Hawk County medical examiner. While in the service he received the Silver Star and several other battle awards for devotion to duty under fire even though he was a medical officer.

Many words have been used to describe Dr. Paul O'Keefe, but there are two phrases unique to him: *"one of a kind"* and *"he was a very kind person."*

His death marked the end of a career of service that will not soon be duplicated. Dr.

O'Keefe was a unique individual. As a physician, his dedication and devotion to patients was deep and unsparing of himself. During his long career as Black Hawk County medical examiner, it was in the arena of violence that his gentle nature perhaps was best revealed.

In all the years of answering calls to scenes of violent death, Dr. O'Keefe never lost his sensitivity to the human loss which those grisly incidents exacted. There was nothing callous or unfeeling about the way Paul O'Keefe carried out the grim but necessary responsibilities of medical examiner.

The cynicism and selfishness which enveloped much of our culture during the 50 years Paul O'Keefe served the community through his profession never put their mark on him.

That is a legacy that will not be forgotten by those who knew him. — A. M. DOLAN, M.D.

U. OF I. OCME

In the business of assisting in the planning, conducting and evaluating of continuing medical education offerings is the University of Iowa Office of Continuing Medical Education. The Office is fully accredited by the American Medical Association to devise and co-sponsor programs to enable physicians to acquire Category I credit for the AMA's Physician's Recognition Award.

In 1977-78 the Office of Continuing Medical Education was involved in 178 programs, recorded 8,686 registrations, and had 1,476 faculty participations to involve 6,248 hours.

The U. of I. College of Medicine and the Office of Continuing Medical Education are

seeking to respond to the important and lifelong educational needs of physicians and allied health personnel.

Acknowledgement is made of the year-around service provided by Richard M. Caplan, M.D., U. of I. Associate Dean for Continuing Medical Education. Dr. Caplan is a member of the scientific editorial panel of the JOURNAL. He is the author of the EDUCATIONALLY SPEAKING feature which appears in the JOURNAL, and he assists with the editorial program in various other helpful ways.

Inquiries regarding services or requests for assistance should be addressed to The Office of Continuing Medical Education, University of Iowa College of Medicine, 285 Med Labs, Iowa City, Iowa 52242 (1/310/353-5764).

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ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

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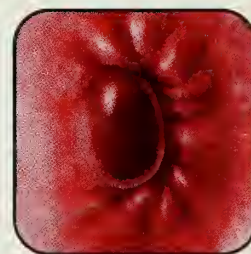
secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

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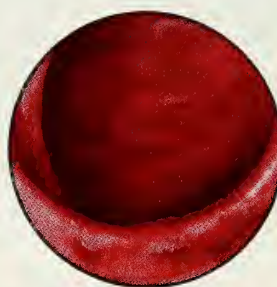
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hemorrhoids



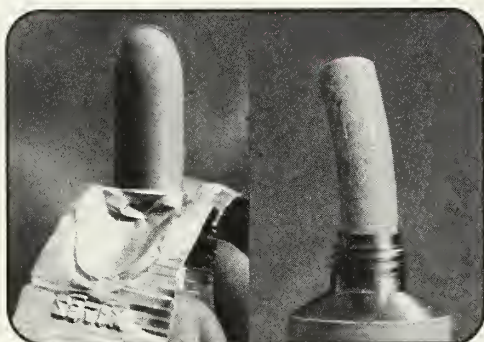
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Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani. Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol-HC Suppositories or Ointment.

Contraindications: Anusol-HC® Suppositories and Anusol-HC® Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

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Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

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Caution should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. One suppository in the morning

and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24); in silver foil strips with Anusol-HC W/C printed in black.

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Thanks to Physician Preceptors

The University of Iowa College of Medicine extends sincere appreciation and thanks to the more than 180 Iowa physicians who served during the 1977-78 academic year as preceptors for third- and fourth-year medical students and for students in the Physician's Assistant Program. These preceptorships are an important element in the College's outreach effort. They permit students to observe the opportunities, and clinical problems, of a medical practice away from the academic setting represented by The University of Iowa Health Center.

Figure 1 shows community locations of physicians who served as preceptors for the medical students in the courses called "Preceptorship in Primary Care."

IOWA PHYSICIAN PRECEPTORS IN 1977-78 ACADEMIC YEAR

SERVED 4TH YEAR STUDENTS/CLASS OF 1978

Ankeny	Rodney R. Carlson, M.D. (1)*
Bloomfield	Mork D. Pobst, M.D. (1)
Cedar Rapids	Mork J. Tyler, M.D. (1)
Charles City	Werner P. Pelz, M.D. (1)
Council Bluffs	James T. Mulry, M.D. (1)
Des Moines	Robert W. Anderson, M.D. (1)
Monillo	John M. Hennessey, M.D. (1)
Moquoketo	John A. Bromon, M.D. (1)
Mason City	John C. Justin, M.D. (1)
	Richard E. Munns, M.D. (1), L. W. Swanson, M.D. (2)
Orange City	Carl Vonder Kooi, M.D. (1)
	Poul W. Vonder Kooi, M.D. (1)
Red Oak	Charles E. Driscoll, M.D. (3)
Spencer	John E. Kelly, M.D. (1)
Story City	Craig J. Chopple, M.D. (1)

* Indicates number of students.

SERVED 3RD YEAR STUDENTS/CLASS OF 1979

Ackley	Horry O. Stoutland, M.D. (1)
Anomoso	John L. Bailey, M.D. (1)
Ames	Thomas J. Dry, M.D. (1)
	Kennedy C. Fowcett, M.D. (1), William C. McCormock, M.D. (1), George E. Montgomery, M.D. (1)
Bettendorf	William C. McCabe, M.D. (2)
	Edwin A. Motto, M.D. (1), Alon R. Sweering, M.D. (3)
Bloomfield	Mork D. Pobst, M.D. (1)
Boone	John R. Anderson, M.D. (1)
	John F. Murphy, M.D. (4)
Burlington	William Anderson, Jr., M.D. (1)
	Horry N. McMurray, M.D. (1), Warren C. Zobloudil, M.D. (1)
Cedar Falls	Philip E. Rohrbough, M.D. (2)
Cedar Rapids	Arthur E. Bornes, M.D. (1)

(List continued on page 160)

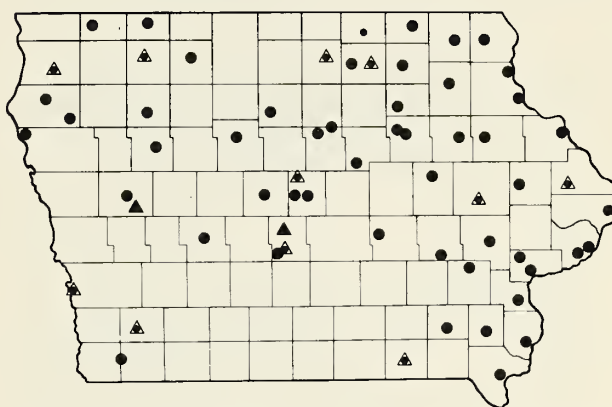


Figure 1. Third-year required preceptorships involved 112 physicians from 62 Iowa communities and served 165 medical students (● indicates locations). The fourth-year elective preceptorship involved 16 physicians in 13 Iowa communities and served 15 medical students (▲ indicates community). (Δ indicates communities where both juniors and seniors were preceptors.) The Physician's Assistant preceptorship involved 55 physicians in 19 Iowa communities (not indicated on map).

Percy G. Harris, M.D. (1), James F. Stiles, M.D. (1), Robert L. Swaney, M.D. (3), Mark J. Tyler, M.D. (3)
 Charles City Werner P. Pelz, M.D. (3)
 Clinton George W. Morme, M.D. (1)
 George L. York, M.D. (3)
 Conrad Dohn R. Kruschwitz, M.D. (1)
 Council Bluffs Elmer O. Beon, M.D. (1)
 Yuksel A. Inankur, M.D. (1)
 Cresco Peter F. Kepros, M.D. (1)
 Davenport Borry Borudin, M.D. (1)
 John F. Collins, M.D. (1), Dorothy Gildeo, M.D. (1), Atlee B. Hendricks, M.D. (2)
 Decorah James A. Bullord, M.D. (2)
 Denison Doyrle N. Crobb, M.D. (1)
 Des Moines James L. Blessmon, M.D. (1)
 T. D. Ghrist, M.D. (1), Daniel A. Glomset, M.D. (1), Charles H. Gutenkouv, M.D. (1), H. R. Hornberger, M.D. (1), Donald F. McBride, M.D. (1), John K. Uchiyomo, M.D. (1)
 Dubuque John S. Chapmon, M.D. (2)
 Eugene W. Coffman, M.D. (1), William J. Doll, M.D. (1), Robert T. Melgoord, M.D. (1)
 Eagle Grove Dole A. Hording, M.D. (1)
 Emmetsburg Corlyle C. Moore, M.D. (1)
 Fairfield Gene E. Egli, M.D. (1)
 Fort Dodge Richard H. Brondt, M.D. (1)
 Charles L. Dogle, M.D. (1)
 Fort Madison Miles H. Archibald, M.D. (1)
 Artemio C. Santioga, M.D. (1)
 Grinnell James B. Poulson, M.D. (1)
 Bernhard G. Wiltfang, M.D. (2)
 Guthrie Center Herbert Neff, M.D. (1)
 Guttenberg Eugene M. Downey, M.D. (2)
 Robert J. Merrick, M.D. (1)
 Iowa City Anthony O. Colby, M.D. (6)
 Victor G. Edwards, M.D. (5), Charles R. Eicher, M.D. (1), Nyle Kouffmon, M.D. (1), Larry G. Rigler, M.D. (3), Mitchell C. Ruffcorn, M.D. (2)
 Iowa Falls Herbert E. Gude, M.D. (1)
 Kolono Dwight G. Sottler, M.D. (2)
 Kingsley Charles E. Homm, M.D. (1)
 Le Mars Donald K. Faber, M.D. (1)

Monchester Mory Ann Arends, M.D. (1)
 John E. Tyrrell, M.D. (1)
 Moquoketo Clifford L. Rosk, M.D. (1)
 Mason City John H. Brinkman, M.D. (1)
 L. W. Swanson, M.D. (1), J. D. Thoreson, M.D. (1), R. Bruce Trimble, M.D. (1), George H. West, Jr., M.D. (1)
 McGregor Donald W. Pfeiffer, M.D. (1)
 Mount Pleasant Phillip Couchmon, M.D. (2)
 Muscotine Forrest Deon, M.D. (1)
 Stephen S. Krogh, M.D. (1)
 Nevada Jerold King, M.D. (1)
 New Hampton James C. Corr, M.D. (2)
 North English Lawrence A. Miller, M.D. (1)
 Orange City Poul W. Vonder Kooi, M.D. (1)
 Osage M. C. Steine, M.D. (1)
 Red Oak Charles E. Driscoll, M.D. (7)
 Jock D. Fickel, M.D. (2)
 Rockford R. Gene Borrett, M.D. (1)
 Soc City Rodney H. Miller, M.D. (1)
 David R. Youberg, M.D. (1)
 Shenandoah Kenneth J. Gee, M.D. (1)
 Sibley William E. Hicks, M.D. (1)
 Sioux City William L. Jackson, M.D. (1)
 Frederick J. Lohr, M.D. (1)
 Spencer John E. Kelly, M.D. (3)
 Spirit Lake Maurice Kirlin, M.D. (1)
 F. D. Rodowig, Jr., M.D. (1)
 Storm Lake Gory C. Olson, M.D. (1)
 Story City Craig J. Chapple, M.D. (1)
 Vinton Don C. Weidemon, M.D. (1)
 Wapello Leslie E. Weber, M.D. (1)
 Waterloo Hridendram N. Bosu, M.D. (1)
 Robert E. Morrison, M.D. (1), Ronald R. Roth, M.D. (3), Thomas R. Sprogg, M.D. (2), Thomas F. Thornton, Jr., M.D. (1), Robert A. Weyrouch, M.D. (1)
 Waukon Louis B. Broy, M.D. (2)
 Waverly James W. Rothe, M.D. (1)
 West Des Moines James E. Dolan, M.D. (1)
 West Liberty Howard C. Palmer, M.D. (4)
 West Union Lorry H. Boeke, M.D. (2)
 Winthrop Alfred E. Moyner, M.D. (1)

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 Boone John F. Murphy, M.D.
 Cedar Rapids L. D. Helvey, M.D.
 William Kettelkamp, M.D., W. J. Robb, M.D.
 Centerville Anthony Owco, M.D.
 Clorindo Kirpal Singh, M.D.
 Davenport Gordon Cherwitz, M.D.
 Eugene L. Johnson, M.D., John E. Sinning, M.D., Forrest W. Smith, M.D.
 Des Moines Michael Abrams, M.D.
 Nabil Foltos, M.D., R. C. Floren, M.D., John Hess, M.D., David T. Koung, M.D., Un Bong Lee, M.D., Sinesio Misol, M.D., Loron F. Parker, M.D. Cheung P. Pun, M.D., William H. Simmons, M.D., F. Eberle Thornton, M.D.
 Dubuque Allen D. Harves, M.D.
 Poul J. Loube, M.D., Robert T. Melgoord, M.D.

Iowa City John P. Albright, M.D.
 Remi J. Codoret, M.D., Rophoel Chung, M.D., Reginald R. Cooper, M.D., Albert E. Crom, M.D., David A. Culp, M.D., Gerold F. DiBono, M.D., Douglas W. Loube, M.D., Michael R. Mickelson, M.D., Ignocio V. Ponseti, M.D., James Stirling, M.D., Richard L. Zuehlke, M.D.
 Loke City Ed Moahs, M.D.
 Marshalltown Terrence L. Briggs, M.D.
 Axel Lund, M.D.
 Moson City Morie O. Alcorn, M.D.
 R. B. Dunker, M.D., W. G. Gorrett, M.D., Richard Munns, M.D.
 Mt. Pleasant Joyont Belsore, M.D.
 Jerome P. Hoger, M.D., Thomas Hansen, M.D.
 Muscotine William Cotocono, M.D.
 Forrest Deon, M.D., David G. Kundel, M.D.
 Oelwein Harold C. Hollberg, M.D.
 Sioux City A. W. Horsley, M.D.
 St. Ansgor William E. Owen, M.D.
 Waterloo Luke Ton, M.D.
 Webster City Subhash Sahoi, M.D.

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ABOUT IOWA PHYSICIANS

Dr. John T. Kelley has been elected president of the Davis County Medical Society. Other officers are **Dr. James R. Mincks**, president-elect; **Dr. Henry M. Perry**, vice president; and **Dr. Jack Dawkins**, secretary-treasurer. All are Bloomfield physicians. . . . **Dr. N. L. Krueger**, Casey, was honored recently by the Casey Community Club for 20 years' service to the surrounding area. Dr. Krueger was presented a plaque noting the recognition. . . . **Dr. Joseph Callaghan**, surgeon at the Winneshiek County Memorial Hospital in Decorah, has accepted a fellowship at the Mayo Clinic in Rochester, Minnesota. Dr. Callaghan will spend two years at the Clinic in reconstructive plastic and hand surgery. He has practiced surgery in Decorah since 1965. . . . A scholarship fund honoring the late **Dr. Robert D. Rowley**, Burlington physician who died March 29, 1978, will offer limited financial assistance to a Burlington area person planning a health care career. . . . **Dr. Bruce J. Vander Kooi** was elected president of the medical staff at Buena Vista County Hospital in Storm Lake. Other officers are **Dr. J. J. Hruska**, vice president and **Dr. T. E. Shea**, secretary-treasurer. All are Storm Lake physicians. . . . **Dr. J. B. Dressler**, Ida Grove, was named citizen of the year by the Ida Grove Chamber of Commerce. Dr. Dressler, who retired from active practice last May, served that community for nearly 40 years. He is a member of American Academy of Family Practice; past president of the Ida Grove School Board; elder and former treasurer of the Ida Grove Westminster Presbyterian Church.

Dr. Luke Tan, Waterloo pediatrician, was instructor at a recent parenting class sponsored by the Hawkeye Institute of Technology. The course was entitled, "How to Take Good Care of Your Kids Without Being Driven Nuts." . . . **Dr. Willard P. Marble**, Marshalltown, has been named a life member of the Marshall County Medical Society. Dr. Marble has been a member of the local medical society, the Iowa Medical Society and the American Medical Association. . . . **Dr. Sterling Laaveg**, Mason

(Please turn to page 163)

Tenuate®
(diethylpropion hydrochloride NF)

Tenuate Dospan®
(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

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Direct Medical Inquiries to:

MERRELL-NATIONAL LABORATORIES
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Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

Merrell

ABOUT IOWA PHYSICIANS

(Continued from page 162)

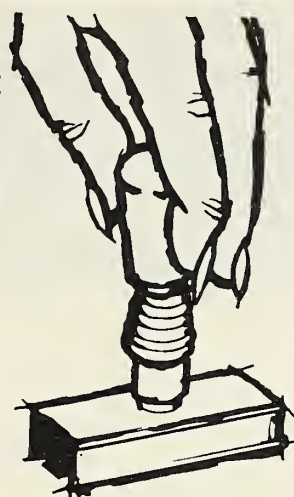
City, was guest speaker at recent meeting of the Wright County Medical Society. Dr. Laaveg, an orthopedic surgeon, discussed hardware and prostheses used in various joints throughout the body. . . . **Dr. Dennis D. Gordy**, Spencer, has been named a diplomate of the American Board of Ophthalmology and a fellow of the American Academy of Ophthalmology. . . . **Dr. Donovan F. Ward**, Dubuque, has been named an honorary member of the Finley Hospital Board of Trustees. Dr. Ward recently returned from Hawaii where he spoke at a combined meeting of the Maui County Medical Society and its Auxiliary in Wailuku, Maui, Hawaii.

DEATHS

Dr. Arnold L. Nelson, 75, longtime Des Moines surgeon, died February 3 at his home in Huxley. Dr. Nelson received the M.D. degree at the U. of I. College of Medicine. He practiced in Winterset for 11 years then relocated in Des Moines, where he practiced until his retirement in 1976. He was a member of the American Association of Abdominal Surgeons and an honorary member of the staff at Iowa Lutheran Hospital in Des Moines.

Dr. Donald W. Hurlbut, 51, Emmetsburg, died February 17 following an accidental gun shot wound at a farm residence near Curlew. Dr. Hurlbut received the M.D. degree at U. of I. College of Medicine and interned at St. Luke's Methodist Hospital in Cedar Rapids. For the past five years, he has been a member of Medical Associates in Emmetsburg.

Dr. Matthew P. Lawler, Jr., 53, Des Moines obstetrician and gynecologist, died February 20 while vacationing with his family in Hawaii. Dr. Lawler received the M.D. degree at Creighton University School of Medicine and served his internship and residency at St. Louis (Mo.) City Hospital. He had practiced



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obstetrics and gynecology in Des Moines since 1951. Dr. Lawler was a diplomate of the American Board of Obstetrics and Gynecology; member of American College of Surgeons; and chief of staff of obstetrics and gynecology at Mercy Hospital Medical Center.

Dr. Paul T. O'Keefe, 79, Waterloo physician for 50 years, died February 7 at St. Francis Hospital in Waterloo. Dr. O'Keefe received the M.D. degree at St. Louis School of Medicine; interned at St. Anthony's Hospital in St. Louis; and located in Waterloo in 1926. (See page 156.)

Dr. Joel M. Linford, 41, Des Moines, died February 17 at Mercy Hospital Medical Center in Des Moines. Dr. Linford received the M.D. degree at University of Pennsylvania; and interned at Salt Lake City, Utah. He located in Des Moines in 1963, and was a partner in Hill-top Medical Clinic and a medical staff member at Iowa Lutheran Hospital, Broadlawns Medical Center, Mercy Hospital Medical Center, Iowa Methodist Medical Center and Northwest Community Hospital.

State Department of Health

AFTER HOURS CONTACTS

The Iowa State Department of Health has always been ready and willing to answer requests from Iowa physicians for advice or assistance at night and on weekends, just as during regular working hours. However, we have not had a routine system to make these contacts as easy as possible. To correct this, the department has now implemented an after-hours call system with the assistance of the Division of Communications of the Iowa Department of Public Safety.

The department has assigned about 20 Division or Section Directors to serve one-week

assignments as duty officers. The duty officer will carry a pager which can be activated by the Department of Public Safety dispatcher. To contact the Health Department after hours call 515/281-3561. The dispatcher will contact the duty officer, who will call you. We hope this will make it easier for you to reach the department after hours for any help you need, such as rabies consultation and vaccine. If you know the name of the person in the department you want to contact, you may still feel free to reach him/her directly at home if you wish.

Below we have listed for your general reference the office telephone numbers of the various department sections. If you are in doubt concerning which section you may need, the general information number is 515/281-5787.

IOWA STATE DEPARTMENT OF HEALTH TELEPHONE LISTING

COMMISSIONER	281-5605
Assistant Commissioner, External Affairs	281-4951
Assistant Commissioner, Office of Management and Budget	281-3877
Assistant Commissioner for Planning	281-4342
COMMUNITY HEALTH DIVISION	
Deaf Services	281-4903
Emergency Medical Services	281-4262
Nursing Section	281-4912
DISEASE PREVENTION DIVISION	
Immunization	281-4936
Infectious Disease Control	281-5424
Tuberculosis	281-4917
Venereal Disease	281-4929
Veterinary and Public Health	281-5643

HEALTH FACILITIES DIVISION	
Long Term and Hospital Construction	281-4227
Long Term Licensure (Care Facilities)	281-4237
Short Term (Hospital) and Medicare	281-4114
Mental Health Facilities Construction	281-3161
Nutrition & Dietary Management	281-4125
Rehabilitation — Consultation	281-3383
PERSONAL AND FAMILY HEALTH DIVISION	
Dental Health	281-4916
Health Engineering	281-4942
Maternal and Child Health	281-4914
Family Planning	281-3283
Sudden Infant Death Syndrome—	
Genetic Counseling	281-3126
Women, Infants and Children, Supplemental Food Program	281-4919

PROGRESS REPORT — ADVANCED EMS

The Advanced Emergency Medical Care Council, the Board of Health (State Health Department) and the Board of Medical Examiners have approved the final draft of the proposed rules intended to implement the advanced emergency medical care law: "An Act relating to the training and certification of and the services performed by advanced emergency medical technicians and paramedics, authorizing the Department of Health and the Board of Medical Examiners to make rules pursuant to this act with the advice of an advanced emergency medical care council, and imposing penalties."

These proposed rules have now formally entered the rule-making process. On March 30, 1979, copies were mailed to: ambulance and rescue squad service programs, emergency

department physicians, schools of nursing, area community colleges and the Iowa Medical Society. Anyone not included in this mailing may request a copy by writing to Mike Guely or calling 1-515-281-4962. The purpose of the mailing is to solicit comments from the general public and those particularly interested in advanced emergency medical care. To this end, a public hearing shall be held in Des Moines, Thursday, April 26, 1979, at 10 a.m. in the first floor conference room of the Wallace State Office Building (East Ninth and Grand).

The Advanced Emergency Medical Care Council and representatives of the Iowa State Department of Health and the Iowa Board of Medical Examiners will attend. Oral presentations will be received on the proposed rules. Written comments may be submitted no later than 4:30 p.m., Wednesday, April 25, 1979, to Mike Guely, Acting Director, Iowa State Department of Health, Emergency Medical Services Section, Lucas State Office Building, Des Moines, Iowa 50319.

February 1979 Morbidity Report

Disease	Feb. 1979 Total	1979 to Date	1978 to Date	Most Feb. Cases Reported From These Counties
Amebiasis	6	13	27	Bremer, Boone, Dallas, Floyd
Brucellosis	0	1	3	NA
Chickenpox	1603	2573	1449	Scattered
Encephalitis, viral	1	3	2	Warth
Giardiasis	1	7	3	Cerro Gorda
Hepatitis, A	18	37	18	Scattered
Hepatitis, B	8	14	19	Boone, Dubuque, Floyd, Palk, Scott
type unspecified	6	7	8	Muscataine, Story, Buchanan, Emmet, Butler, Crawford
Herpes simplex	10	13	14	Scott, Johnson, Montgomery
Infectious mononucleosis	93	125	154	Scattered
Meningitis aseptic	2	12	0	Blackhawk, Dubuque
bacterial	6	20	16	Delaware, Warren, Marian, Palk, Scott
meningococcal	1	3	1	Polk
Mumps	37	54	21	Scattered
Pertussis	0	0	0	NA

Disease	Feb. 1979 Total	1979 to Date	1978 to Date	Most Feb. Cases Reported From These Counties
Rabies in animals	10	25	29	Marshall, Cass, Chick- asaw, O'Brien, Van Buren, Dallas, Davis, Iowa, Hardin
Rubella	2	2	6	Johnson, Pattawattamie
Rubeola (measles)	1	1	1	Mahaska
Salmonella	12	20	24	Scattered
Shigella	4	11	3	Johnson, Dallas, Scott
Tuberculosis total ill	7	18	13	Blackhawk, Palk, Cedar, Linn, Wa- pella, Pattawattamie
bact. pas.	5	16	13	Blackhawk, Palk, Wapello, Cedar
Venereal diseases: Gonorrhea	476	938	905	Scattered
P. & S. Syphilis	1	4	6	Madison

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Eaton's agent — 8, scattered; Erythema infectiosum — 85, scattered; Rheumatic fever — 1, Ringgold; Gastroenteritis — 3658, scattered; Influenza-like illness (URI) — 17,113, scattered; Russian flu (lob confirmed) — 24, scattered.

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WANTED — Board Cert. or Board Elig. Internist, Gen., or with subspecialty. Univ. Comm. of 40,000 with drawing area of about 100,000. 1 hr. from ocean, mountains, or desert. 6 mos. guar. income. J.A.C.H. approved Hosp., lic. for 195 beds. Address resume to Box 1506, Loma Linda, California 92354.

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Presidential Comments On the Year Gone By



This has been a good year to be president of the Iowa Medical Society. I want first to thank the officers and the staff for helping with all of the duties assigned to the president. This assistance has made the year much easier.

I want also to thank the committee chairmen and their committees for all the work done. A considerable amount of physician time is given in this connection for the benefit of the profession and the public.

Indeed, the staff has been a great help to me all year. I appreciate this effort.

The Iowa Medical Society is in excellent financial shape right now. We have 90% of the eligible Iowa physicians as members. We have refurbished our building. It looks good. Our malpractice premiums have decreased. We have managed to es-

cape increased federal control for one more year.

I know Dr. Paul Seebohm will be an excellent president. I look forward to great things from the Iowa Medical Society this coming year.

A handwritten signature in cursive script that reads "Russ Gerard".

Russell S. Gerard, M.D.

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JOURNAL OF THE

IOWA medical society

VOL. 69, No. 5

MAY 1979

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The Question Box

by H. E. WICHERN, M.D.

AHA REPRESENTATIVE

Homer E. Wichern, M.D., represents Iowa physicians and those from several other states in the American Hospital Association. A surgeon in private practice in Des Moines, Dr. Wichern comments briefly on his AHA service.

What is your role as a physician delegate to the American Hospital Association? Do you represent Iowa only or a broader base?

Since 1974 it has been my privilege to represent the medical staffs of member hospitals in the states of Minnesota, Iowa, Missouri, Kansas, Nebraska, and North and South Dakota. These states constitute Region 6, one of nine regions in the country as a whole.

What are the major issues now confronting this body?

The "Voluntary Effort" in cost containment is our primary consideration and effort at this time. A highly structured organizational movement through the VE National Steering Committee is challenging the proposed legislation to impose a mandatory federal cap on hospital charges. James Sammons, M.D., AMA executive vice president, discussed the physician's role in the VE at our February meeting. It appears to me it will be difficult for phy-

sicians to achieve the full objective in cost containment, but it is the goal of the AMA and AHA. It is important for physicians and hospital administrators to join in pursuing the goal. Health planning is another important topic with all of its legislative and practical problems. Other current topics include shared services; uniform hospital accounting reporting; Blue Cross and Blue Shield reimbursement for routine hospital admission tests; patient education; training of physicians, nurses and allied health personnel; employee union activities, and last, but not least, government regulations (always on the increase) in all areas of health care.

How often does the AHA policy-making body meet?

The members of the AHA House of Delegates from these states meet four times a year. The full House of Delegates meets in August around the country and in February in Washington, D. C. In 1974 each region elected one physician and one trustee as full voting delegates. My duty is to present the viewpoint of all the medical staffs in AHA deliberations.

In your judgment, is the AHA House of Delegates pursuing those positions which are in the interest of medicine and the public?

The AHA and its member organizations are dedicated to the principal of free enterprise. An excellent job is being done to maintain a suitable "shop" in which the physician can work. The quality of patient care and the public good are of the highest priority.

Educationally Speaking



by R. M. CAPLAN, M.D.

FEES FOR CME

Occasionally one hears words of distress about the fees charged for CME activities. These complaints have led to formal expressions of concern in resolutions of the House of Delegates of the Iowa Medical Society and also the AMA. It is gratifying that the preamble to the Iowa resolution acknowledged that no intra-state abuses had existed, but the total resolution served as a kind of warning to any who would listen, and would care.

The expressed concerns that I have heard are partly justified and partly not. Yes, ripoffs indeed exist. There are educational entrepreneurs inside and outside of academe who have sensed what they consider a potential goldmine, and can't rest without trying to mine that gold.

On the other hand, most practitioners have limited knowledge of the financing of educational enterprises. It takes experience as a planner or administrator, or a member of a school board or board of trustees, to attain a real sense of what money it takes to provide what education. For example, most Iowa practitioners have no idea that our state legislature provides only about 20% of the operating budget for The University of Iowa College of Medicine.

As is true for so many products and services, the costs to produce education are generally related to the quality of that education. If the present national rate of about \$10 per credit hour is viewed as excessive, perhaps it should

be compared to the fees charged currently for riding lessons, singing lessons, language tutoring, or repairing sick TV sets or leaking faucets. Nationally, undergraduate medical students pay tuition in the range of \$10 per hour, but neither they nor their parents may deduct the expense from income tax.

High quality CME requires more planning time than is known to any but those who have done it. And it requires attention to a host of small details. And it requires appropriately expert individuals as teachers. Such time, effort, and expertness do not come cheap. And when the people doing that work are largely physicians (as they must be to plan, deliver and evaluate medical education), then it is uncheap, in spades! Or at least it would be if any sort of reasonably accurate cost-accounting were done. Organizations that exist specifically in behalf of education must naturally pay attention to that sort of accounting. I'd be glad to offer some tutoring or on-the-job training to any who want to learn more about it, since I think the world presently needs more well-trained leaders in CME.

So what is the practitioner to do? Do exactly what you do in other spheres of life: decide what you need or want, shop for it (that is, see the JAMA catalogue, read the brochures that come your way, ask of those who are purveyors), consider the goals and content of the offered activity, remember or learn what you can about the general quality of the purveyor and the purveyor's previous educational efforts, and then choose what seems to you the best educational buy for the money. And remember, the fees (or call it tuition) are not only

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

(Please turn to page 182)

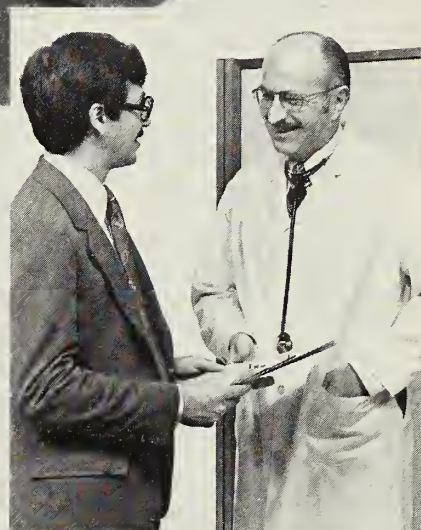


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EDUCATIONALLY SPEAKING

(Continued from page 181)

tax-deductible but are almost always a much smaller component of the cost than travel, lodging, meals and being away from your earning station. If you think a particular CME offering is not worth that total cost, avoid it. There's now lots of choice. In that way the traditional market place factors might operate and get rid of some of the crap.

No, Virginia, there is no free lunch. Those who yearn for it might like to check out the British method. Their National Health Service provides loads of free CME, and pays the physician's travel expense and a *per diem* besides. But there is a large hidden cost that I think you know without my further elaboration.

MEDICAL MISCELLANY

COUNCILORS RENAMED . . . Three IMS district councilors were given new three-year terms by their physician constituents. New terms were ratified by the House for C. L. Kelly, M.D., Charles City, District 1; D. M. Youngblade, M.D., Sioux City, District 4; R. T. Guthrie, M.D., Waterloo, was named to succeed A. M. Dolan, M.D., in District 6; and A. L. Sciortino, M.D., Council Bluffs, District 11.

REGIONAL CME . . . A July 21/22 continuing medical education event will be available in Minneapolis under auspices of the American Medical Association. This regional CME event is offered in cooperation with the University of Minnesota Medical School and the Minnesota State Medical Association. Topics included are basic electrocardiography, cardiac arrhythmias, office gynecology, communications for the medical speaker, chest roentgenograms, emergency management of life threatening injuries, advances in drug therapy, enhancing your financial skills.

MEDICAID . . . Direct payment to psychologists for Medicaid services were authorized in April. Also liberalized were Title XIX guidelines for obesity and plastic surgery.

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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SCIENTIFIC ARTICLES

Opinions of Iowa Physicians On Obstetrical/Neonatal Care

HERMAN A. HEIN, M.D., and

WILLIAM C. KEETTEL, M.D.

Iowa City

Views of Iowa physicians on perinatal care are reported. The report is based on a survey of family practitioners, obstetricians and pediatricians. Health planners are urged to solicit medical expertise from private practice physicians.

IN 1973, THE STATEWIDE PERINATAL CARE TEAM began a program of problem oriented perinatal education in Iowa. Most Iowa hospitals providing obstetric care were visited by the team and assessments of care practices were made. Educational programs were presented to strengthen perinatal care.

Individual visits to the smaller hospitals are no longer being made. However, the perinatal team has continued its educational programs for physicians and nurses, and has maintained a problem oriented approach. Obstetric and newborn practices continue to be surveyed and the results are the basis for the educational

programs conducted for small groups of hospitals.

The general approach of the Statewide Perinatal Care Program has been to assess needs on a first hand basis and to avoid attaching preconceived ideas to Iowa perinatal practices. To examine Iowa custom, the authors developed a questionnaire for practicing physicians to comment on certain aspects of perinatal care. The questionnaire was sent to family physicians doing obstetrics and newborn care, to pediatricians, and to obstetrician/gynecologists.

RESULTS OF THE QUESTIONNAIRE

The responses to the questionnaire were tabulated for each of the three groups noted above.* Twenty-six multifaceted items were surveyed and grouped into 11 categories as shown in Table I.

Dr. Hein is an associate professor in Department of Pediatrics at U. of I. College of Medicine and director, Iowa Statewide Perinatal Care Program. Dr. Keettel is a professor in Department of Obstetrics and Gynecology at the U. of I. College of Medicine.

* A complete summary of the results of the questionnaire is available upon request from the authors.

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE
AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF MAY 1979.

TABLE I
ITEMS SURVEYED

I. Family centered obstetrics.
II. Preparation for childbirth.
III. New feelings about old practices.
IV. Facilities, equipment, providers, and time-distance factors.
V. Health extenders.
VI. Drugs for anesthesia and pain relief.
VII. Regional availability of perinatal services.
VIII. Postgraduate medical education.
IX. Perinatal concerns.
X. Contact with health planners.
XI. Statistics.

I. FAMILY CENTERED OBSTETRICS

All 3 groups of physicians indicated husbands should be permitted in the labor area, and the majority would allow husbands in the delivery room with physician concurrence. The majority of family physicians and obstetricians accepted rooming-in, but did not encourage it, while 56% of the pediatricians actively supported rooming-in.

II. PREPARATION FOR CHILDBIRTH

Three-fifths of the physicians doing obstetrics actively encourage preparatory childbirth education. A majority of the rest said it should be provided, but not encouraged.

III. NEW FEELINGS ABOUT OLD PRACTICES

Opinions were solicited on circumcision and breast feeding. It was interesting to note that family physicians and obstetrician/gynecologists were more apt to endorse circumcision (58.1% and 53% said it should be actively encouraged) than pediatricians (only 32.5% were willing to recommend the procedure). However, few physicians in any of the three groups disapproved of the procedure. The American Academy of Pediatrics has discouraged the routine use of circumcision.¹ This, perhaps, accounts for the difference in opinion between family physicians and pediatricians.

Breast feeding was actively encouraged by the pediatricians (94%); family physicians (76%), and obstetricians (62%). It is difficult to explain why the latter group was the least interested in encouraging breast feeding.

IV. FACILITIES, EQUIPMENT, PROVIDERS, AND TIME-DISTANCE FACTORS

There was a striking difference in opinions on distance obstetric patients are willing to travel for hospital care. On the average, the family physicians suggested patients are willing to travel 26 miles, while pediatricians and obstetricians replied patients are willing to travel almost twice as far. On the other hand, all three groups of physicians did not want to travel long distances to the hospital. The pediatricians were willing to travel 18 miles, the family physicians, 14 miles, and the obstetricians, 11 miles. These distances may reflect the frequency of night visits to the hospital.

A majority of physicians in all 3 groups believed strongly their patients are receiving adequate perinatal services in their local hospitals. When asked to rank 3 possible solutions for improving hospital services, the following were mentioned: (1) improving services in the local hospital, (2) referring patients to larger hospitals in existing population centers, or (3) forming newer, larger hospitals in rural areas by combining existing facilities. The majority of physicians indicated support for retaining local facilities.

The questionnaire asked for recommendations to improve hospital obstetric care. Responses from family physicians in both neonatal and obstetric areas called for improved quality and quantity of nurses as a first priority; this also was the second choice of obstetricians and pediatricians. First choice of pediatricians and obstetricians was a need for regionalized services in a single hospital. The responses on how to improve newborn care included a need for more pediatricians and continuing education for physicians in newborn care.

Physicians were asked to state if a shortage of certain types of physicians existed in their geographic areas. The response is shown in Table II.

A majority of family practitioners, 51.9%, said more in their specialty were needed to take an interest in obstetrics and pediatrics. They did not feel the need for obstetricians/gynecologists and pediatricians in their areas.

Fifty-six and three-tenths per cent (56.3%) of the obstetricians answered more family practitioners could be used in their areas, but pedia-

TABLE II
SHORTAGE OF PHYSICIANS

	Yes	No
a. Family Physician interested in Obstetrics and Pediatrics?		
Family practitioners	175	162
Obstetrician/gynecologists	36	28
Pediatricians	12	23
b. Obstetrician/gynecologist:		
Family practitioners	99	249
Obstetrician/gynecologists	31	33
Pediatricians	10	23
c. Pediatrician:		
Family practitioners	111	220
Obstetrician/gynecologists	40	24
Pediatricians	13	23

tricians rejected this (34.3%). The obstetrician/gynecologists were equally divided on a perceived shortage in their specialty, whereas only 30.3% of the pediatricians declared there was a shortage of obstetricians/gynecologists. The majority of obstetrician/gynecologists determined there was a shortage of pediatricians.

With concern over physician manpower, it is interesting to note the physicians' perception regarding perinatal providers. The combined response of all three groups shows 51.5% believe there is a shortage of family practitioners; 38.1% feel more pediatricians are needed; and 31.5% indicate the number of obstetrician/gynecologists is inadequate. Thus, the response tend to indicate the existing number of perinatal physicians is not a major problem in Iowa except in localized areas.

The need for electronic fetal heart rate monitoring in every hospital delivering babies has been debated. Iowa physicians responded as shown in Table III when asked if they would like monitoring available in each Iowa hospital delivering babies:

TABLE III
NEED FOR FETAL HEART MONITORING

	Yes	No	No Opinion
Family practitioners	178	116	109
Obstetrician/gynecologists	31	15	16
Pediatricians	28	6	2

It is difficult to interpret the responses on the availability of electronic fetal monitoring in each hospital delivering babies. About one half of the obstetricians and family physicians said it should be, but one-fourth had no opinion and one-fourth were opposed. This difference in opinion, no doubt, is a reflection of the merits of external versus internal monitoring, the size of obstetric unit, the number of patients at risk, and the availability of trained personnel.

V. OPINIONS ON HEALTH EXTENDERS

Table IV summarizes two questions asked regarding the use of health extenders:

TABLE IV
USE OF EXTENDERS

	Yes	No	No Opinion
<i>Should physicians employ more obstetrical or pediatric nurse assistants?</i>			
Family practitioners	75	162	109
Obstetricians/gynecologists	31	15	16
Pediatricians	11	17	6
<i>Should physicians employ more physicians' assistants?</i>			
Family practitioners	53	193	92
Obstetricians/gynecologists	27	18	15
Pediatricians	7	19	6

While 50% of the obstetricians said more obstetric and/or pediatric assistants should be employed, all three groups generally were not enthusiastic about health extenders. Family practitioners and pediatricians both soundly rejected increased utilization of these personnel.

VI. DRUGS FOR ANESTHESIA AND PAIN RELIEF

The physicians responsible for the conduct of labor and delivery had similar concepts on pain relief in labor and the type of anesthetic agents recommended for a normal delivery. The family physicians recommended some types of inhalation anesthesia as their second choice for delivery over conduction anesthesia, while obstetricians listed inhalation anesthesia as their fourth choice. The pediatricians were content with little or no medication during labor and local block for delivery.

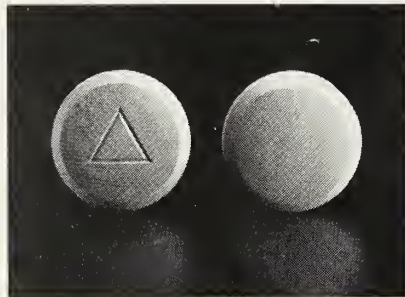
(Please turn to page 192)

The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally “expensive” and generic versions are relatively “cheap.” To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only “expensive” brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

(Continued from page 189)

VII. REGIONAL AVAILABILITY OF RELATED OBSTETRIC SERVICES

The vast majority of physicians surveyed believe family planning services and pregnancy termination services are readily available in their area. They also noted obstetric patients were receiving adequate prenatal care.

VIII. POSTGRADUATE MEDICAL EDUCATION

Physicians were asked to rank the following choices in terms of the most effective method of postgraduate medical education.

1. *Postgraduate course – University sponsored in your area.*
2. *Postgraduate course – University sponsored at the University.*
3. *Medical meeting, state meeting, national meeting, etc.*
4. *Individual reading.*
5. *Audiotapes.*

Family physicians differed from the other two groups in their perception of the most effective form of postgraduate medical education. They opted for postgraduate courses on a local basis, whereas pediatricians and obstetricians preferred to go to the University. It was interesting to note all three groups ranked audiotapes at the bottom of the suggested list of 5.

IX. PERINATAL CONCERNS

Physicians were asked to list their single biggest problem in obstetric and/or newborn care. In general, the physicians delivering babies expressed a concern for heavy workload, insufficient time off and a heavy night call schedule. Regarding newborn care, family practitioners indicated the care of distressed newborn infants, particularly those with prematurity and respiratory distress syndrome, represented their major concern. They commented on the shortage of pediatricians and a desire for more neonatal intensive care facilities in their area. The obstetricians indicated a need for more pediatricians and improved neonatal care facilities in the hospital providing most of the obstetrical care. The pediatricians wanted improved Level II facilities and better cooperation with obstetricians.

X. CONTACT WITH HEALTH PLANNERS

Physicians were asked whether they had any contact with health planners either by the Comprehensive Health Planning group or the Health Systems Agency and responded as shown in Table V:

TABLE V
CONTACT WITH PLANNERS

	Fam. Prac.	Ob/Gyn	Peds.
They have not contacted me.	185	39	20
A superficial contact has been made.	77	14	8
My feelings have been adequately assessed.	62	7	5

While consumers appear drawn more and more into health planning, physicians are not being adequately contacted by the health planning agencies. The majority of physicians in all three groups indicated their feelings have not been adequately assessed.

XI. STATISTICS

A total of 349 family practitioners, 66 obstetrician/gynecologists, and 39 pediatricians responded to the questionnaire. On the average, the family practitioners delivered 50 babies and the obstetrician/gynecologists delivered 221. As expected, the family practitioners tended to be in the smaller Iowa communities while the obstetricians and pediatricians were almost exclusively located in the communities greater than 25,000 population.

SUMMARY AND CONCLUSIONS

Iowa perinatal physicians responding to the questionnaire delivered approximately 74% of Iowa's babies in 1975. A large number of conclusions are not possible from this survey, nonetheless, the consensus expressed in certain areas has been shared with the appropriate persons and departments.

Most physicians indicated an acceptance of a more active role for fathers in the process of labor and delivery. Also, most were in favor of preparatory childbirth education.

The practice of circumcision, while generally supported by family practitioners and obstetricians, was encouraged less by pediatricians. Breast feeding was supported by all three

groups, but to a lesser degree by obstetricians.

A number of issues relating to future health care planning were contained in the questionnaire. It was interesting most physicians believe their expertise has not been adequately assessed by health planners. The physicians, however, did express concise opinions on issues relating to future health planning. The family physicians want to retain local obstetric facilities and oppose having all deliveries in a regional center. They disagreed with the specialists on distance patients are willing to travel for care. Many physicians indicated local facilities were adequate to meet routine perinatal needs, but at the same time, encouraged provision for regional specialized facilities for the high risk gravida and neonate.

While much has been written on the need for increasing numbers of physicians and physician extenders, Iowa physicians view the matter with less alarm. The use of physician's assistants as health extenders was supported by only 20% of the respondents overall, and health extenders trained specifically as pediatric or obstetric nurse assistants was supported by only 26%. As to the need for other perinatal physicians in the geographic area of the respondents, most indicated the need for more physicians is generally not acute.

There was no unanimity of opinion on the availability of electronic fetal heart monitoring in every hospital delivering obstetric patients.

One-half of the obstetricians and family physicians thought it should be available, but a fourth had no opinion and a fourth were opposed. Perhaps, this difference in opinion is a reflection on the merits of external versus internal monitoring, whether all patients or only those at risk should be monitored, the size of the obstetrical facility and the availability of nurses or those with special training.

The responses of the three groups on preferred forms of postgraduate medical education indicated family practitioners favor local courses furnished by the University. The two other groups are more interested in traveling to the University for their postgraduate medical education. This response is perhaps a reflection of the availability of coverage when the physician is out of town and probably reflects the fact more specialists are in group practice.

We believe strongly Iowa physicians should be heard on matters that affect perinatal practice in Iowa. We urge health planners, public health officials and medical educators to carefully assess the feelings of the "private sector" before embarking on new programs aimed at improving health care.

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MEDICAL MISCELLANY

LOOKING AHEAD . . . Plans for the third Opportunities Fair of the Iowa Family Practice Residents Council are moving forward. The 1979 event will be October 27 at the Hilton Inn in Des Moines. The Fair brings together representatives of communities seeking physicians with FP residents about to enter practice. Communities will be allocated display space on a first come basis. For further info, contact the Office of Community Based Programs, College of Medicine, University of Iowa.

ADMINISTRATIVE MOVE . . . Total administrative responsibility for the medical student loan program of the Scanlon Medical

Foundation/Iowa Medical Society has been transferred to Foundation Headquarters in West Des Moines. This action was confirmed at the recent annual meeting of the Scanlon Foundation. The loan program has been administered from Iowa City since 1953.

ALCOHOL & DRUG MISUSE . . . Four identical interprofessional meetings on "Contemporary Issues of Alcohol and Drug Misuse" are set this month in Atlantic (May 21), Sioux City (May 22), Webster City (May 23) and Spencer (May 24). Speakers will be Harold Moessner, M.D., assistant professor, U. of I. College of Medicine, and director of the Alcoholism Center; and Dennis K. Helling, Ph.D., associate professor and head of the Division of Clinical and Hospital Pharmacy, U. of I. College of Pharmacy.

Pulmonary Stress Testing

JOHN J. SEIDENFELD, M.D.,

KHALIL A. FEISAL, M.D.,

GEORGE N. BEDELL, M.D.

Iowa City

Use of exercise testing is described as a means of assessing the functional components of the gas transport system under stress. Unhealthy performance can be noted and used as a baseline for the future. The equipment required is neither complex or expensive.

TESTING OF PATIENTS during exercise has been undertaken at University Hospitals to better assess the functional capacity of the cardiopulmonary system of gas transport. By this method we objectively assess:

- 1) the subjective symptom of dyspnea,
- 2) the degree of functional disability when compared to norms for a particular age, sex, and level of fitness,
- 3) the requirement for oxygen therapy, and
- 4) the progression or regression of a disease state in response to a therapeutic program.

Clearcut diagnostic usefulness is noted in cases of psychogenic dyspnea, exercise-induced asthma, coronary artery disease and peripheral vascular disease. The differentiation between cardiac and pulmonary causes of dyspnea is possible through an exercise test.¹ Useful diagnostic information will be obtained in patients with pulmonary fibrosis, allergic alveolitis, pulmonary

vascular disease, and obese patients with dyspnea.

Jones² has detailed a number of physiologic responses to exercise, and he has also enumerated normal values for different patient populations. Pulmonary adaptations to exercise include increased minute ventilation (\dot{V}_E), reduced dead space to tidal volume ratio (V_D/V_T), and mild elevation of PaO_2 and $PA-aO_2$. The increase in \dot{V}_E is dependent on breathing frequency (f_b) and tidal volume (V_T). V_T usually plateaus with increasing \dot{V}_E but f_b increases in a linear fashion to a point of exhaustion. \dot{V}_E is dependent in a linear manner on CO_2 output (\dot{V}_{CO_2}) which is an index of the metabolic demands on the exercising patient. If ventilation of non gas-exchanging lung is excessive, V_D/V_T increases. When blood is shunted past poorly ventilated alveoli, $PA-aO_2$ increases inordinately.

Cardiovascular responses to exercise include increased cardiac output (Q_T) dependent on cardiac frequency (f_c) and stroke volume (V_s). As oxygen consumption (V_{O_2}) increases, metabolic demands are met by increased oxygen extraction and increased cardiac output as described by the Fick equation.

$$Q_T = \frac{\dot{V}_{O_2}}{Ca-vO_2} = V_s \times f_c$$

One measure of fitness used in stress testing is the O_2 -pulse (V_{O_2}/f_c) which indirectly reflects cardiac output response to exercise. A more complete discussion of exercise physiology may be found in references 1-3.

BICYCLE ERGOMETRY

In the University Hospital laboratory bicycle ergometry is used for exercise tests. This ergometer is used because work done while cycling is independent of subject weight or walking style in contrast to treadmill exercise. The cycle gives

(Please turn to page 196)

Dr. Seidenfeld was a Fellow of the American Lung Association and was associated with the Pulmonary Disease Division, Department of Internal Medicine, U. of I. College of Medicine, when this paper was prepared. He is now a member of the U. S. Army stationed at Silas B. Hayes Army Hospital, Ft. Ord, California. Dr. Feisal was a visiting professor at the U. of I. and has now returned to the staff of American University in Beirut, Lebanon. Dr. Bedell is professor/director, Pulmonary Disease Division, and director, Pulmonary Function Laboratory, University of Iowa Hospitals.

...in the functional bowel/irritable bowel syndrome*

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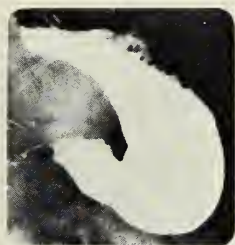
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helps control abnormal motor activity
with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy), obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis), paralytic ileus, intestinal atony of the elderly or debilitated patient, unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis, myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSEAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Ocaturo, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

(Continued from page 194)

equal work loads from test to test when pedalled at a constant frequency. Patients with severe chronic obstructive lung disease may not tolerate low level cycle work, and the treadmill ergometer is used for these patients.

Two primary strategies are used for exercise; a progressive and a steady state test. The progressive test is done with progressively increasing work loads until a pre-determined \dot{V}_c or \dot{V}_E maximum value has been reached or until the patient asks to stop. The steady state test is performed after an appropriate rest period, and work is performed at ⅓ or ⅔ of the maximum load reached on the progressive test. This load is dependent on patient tolerance. The steady state test allows more accurate measurement of work parameters such as \dot{V}_{O_2} , \dot{V}_{CO_2} , \dot{V}_E , f_c , and V_D/V_T and PA-aO₂.

TABLE 1
TESTING MEASUREMENTS AND CALCULATIONS

Measurement	Calculation
Age, sex, hemoglobin, and activity level	
f_c	\dot{V}_{O_2}
\dot{V}_E	\dot{V}_{CO_2}
f_b	V_D/V_T
ECG	PA-aO ₂
BP	
Mixed expired PCO ₂ and PO ₂ at rest and exercise	
Capillary blood ⁴ PCO ₂ , PO ₂ , and pH at rest and exercise	
Barometric pressure	
Temperature (for STP conversion)	
Work output read directly from the ergometer	

Measurements taken during the test are noted in Table 1 along with calculations from these measurements.⁴

Specific details regarding gas analyzers, spirometers, gas collectors, valves, and other instruments may be obtained from Jones² or by direct communication with the authors. The set up may be modified with different inspired oxygen values when testing work output with supplemental oxygen.

Contraindications to pulmonary stress testing include a recent or acute myocardial infarction, pre-infarction angina, severe congestive heart failure, uncontrolled dysrhythmias, acute generalized illness, dyspnea at rest, and symptomatic aortic or carotid stenosis. Patients with suspected coronary artery disease are first evaluated by multi-lead ECG monitoring during treadmill exercise before pulmonary stress testing.

The interpretation of test results requires re-

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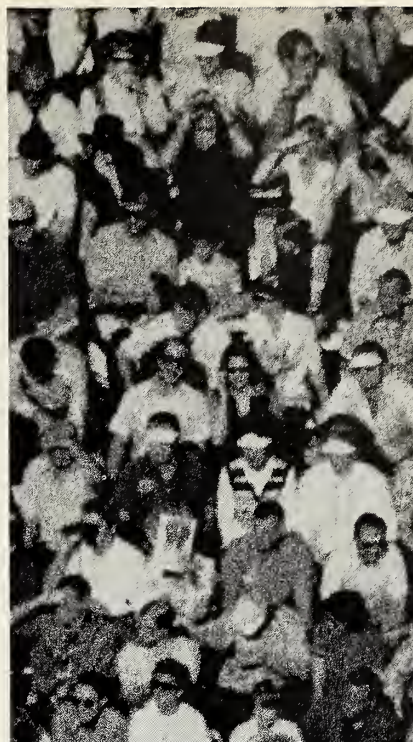
view of the data base to include a complete history, physical examination, CBC, chest x-ray, routine spirometry and resting ECG. Results of the pulmonary stress test are compared with tables of normal values² and to previous tests in this laboratory. These comparisons prove useful in assessing the degree of disability and also in assigning a cause to the complaint of dyspnea. Poor conditioning and submaximal performance are often noted. These conditions are identified if the patient fails to reach the normal range for f_c and \dot{V}_E when maximally stressed.

Improvement in V_D/V_T and PaO_2 with exercise characterizes the response of a patient with COPD whereas decreasing PaO_2 may be seen in the patient with interstitial fibrosis irrespective of the cause. The patient with cardiac dyspnea may evidence a rapid rise in f_c with modest work as compared to the patient with COPD who usually has a normal f_c response. Patients with COPD undergoing exercise rehabilitation therapy may show reduced f_c , \dot{V}_{O_2} , \dot{V}_{CO_2} and \dot{V}_E responses to exercise at the same work load used during a pretraining evaluation.⁵ Exercise-induced asthma will be readily apparent from pre- and post-exercise spirometry. Peripheral vascular disease is expressed symptomatically when the test is stopped because of extremity pain. The patient in whom O_2 therapy is planned to improve work performance should show marked improvement in work tolerance during pulmonary stress testing with O_2 supplied.

In summary, exercise testing allows the assessment of the functional components of the gas transport system under stress. It allows the recognition of unhealthy performance, and sets a baseline for future comparison. The testing we have described requires little complex or expensive equipment. Information may be obtained to answer basic questions regarding exercise capacity, the factors which limit exercise, the symptomatic response to exercise, and specific diagnostic entities. More detailed information will be supplied to anyone with specific questions regarding physiology, equipment, data interpretation, or patient testing at the University of Iowa.

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Editorials

M. E. ALBERTS, M.D., Scientific Editor

ON MEETINGS

Our professional life style dictates that we attend meetings of one sort of another. There are numerous committee meetings, hospital staff meetings, utilization review meetings, or perhaps meetings of a board or two where we might be involved. In years past it seemed a rare evening that I was home with my family. Finally, I determined to be selective and came to a conclusion that many meetings were not to my liking.

A recent issue of THE WALL STREET JOURNAL (March 29, 1979, page 23) carried a full-page comment about meetings. It said three kinds of people attend meetings: those who want progress; those who don't, and those who want to impress the chairman. I would add one other type: the person who is trying to impress upon himself how important he thinks he might be. This would be the person who is always on an "ego trip." He has much to say, but his words say nothing. His comments are empty for the most part. Perhaps he too is attempting to impress the chairman.

The same article said that 98% of meeting talks goes to 2% of the problems. How true that is in many instances. The discussion goes on and on completely skirting the central issues.

The decisions are slow in coming and often drift away from the original intent of the debate.

The chairman of a committee assumes a significant responsibility. In that role there is the necessity to maintain a degree of decorum and to bring direction to the proceedings. Too often a weak chairman loses control and the meeting becomes a free-for-all. The article to which I have referred also suggests that a meeting can be really successful if (1) there are no carafes of ice water; (2) the chairs are uncomfortable, or there are none present, and (3) the thermostat in the room is set at 55. All that might seem a bit ludicrous, but perhaps there is merit in it when seen in the light of some meetings I have attended.

We are learned professional people, well-educated, entrusted with serious aspects of life. We should be able to conduct meetings efficiently so as to expedite the important matters at hand and eliminate much of the insignificant. Life is too enjoyable to spend long hours at meetings. The chairman must plan ahead, direct the proceedings in as sure a manner as the conductor of a symphony orchestra. He must control the non-essential discussion yet still allow for fair appraisal and consideration of the business at hand. — M.E.A.

CONTINUING EDUCATION COURSES & CONFERENCES

Please call or write Office of Continuing Medical Education, College of Medicine, for further information on these programs. Telephone 319-353-5763.

May 10-12
May 14-17

Iowa Eye Association
Cardiology Today

May 24-25
June 11-15

Gastric Bypass
Intensive Course in Pediatric Nutrition

RETIREMENT

Retirement is the ultimate goal of many of us, looking forward to that day when the trials and tribulations of professional life can be set aside for days of leisure and more carefree living. Are you prepared to change your way of life? Can you visualize a daily pattern of living without the challenges of caring for the sick and dying? Are you willing to spend your days playing golf, tennis, reading, doing handicrafts, or perhaps nothing at all?

I once had a dream to retire in a way that one day a week I could provide care to needy children and have the rest of my time free for whatever came along. Much of that dream has been shattered by social developments. The liability ramifications nearly mandate fulltime practice or none at all because of the high cost of insurance. This now must be combined with the requirements of CME for licensure renewal. It would seem our society dictates either full-steam ahead, or no action of any type. So many talents, not only in medicine, are wasted by the all-or-none principle. If a

person retains capabilities and wants to serve out of the goodness of his heart, he should be held less culpable than if it were for a livelihood.

Recently, I visited friends who live in a well-known Arizona retirement settlement. The city is beautiful, the homes nice, the lawns and parks immaculate, and the activities for the residents are varied and many. However, I felt a personal reluctance to remain in such a beautiful city for several factors. First, I have always been surrounded by young adults and children in my practice. I can not conceive of a life with only older people day after day. Furthermore, the presence of much make-work activity frightened me. After all one can use just so many silver belt buckles or bolo-ties. I envisioned the entire scene as a gilt edge, voluntary detention camp. Yes, there was freedom to come and go, but it seemed everyone I talked with had such a calendar of activities that it would be difficult to get away. I was told the incidence of alcoholism and suicide is comparatively high — depression a major problem,

(Continued on page 202)

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RETIREMENT

(Continued from page 201)

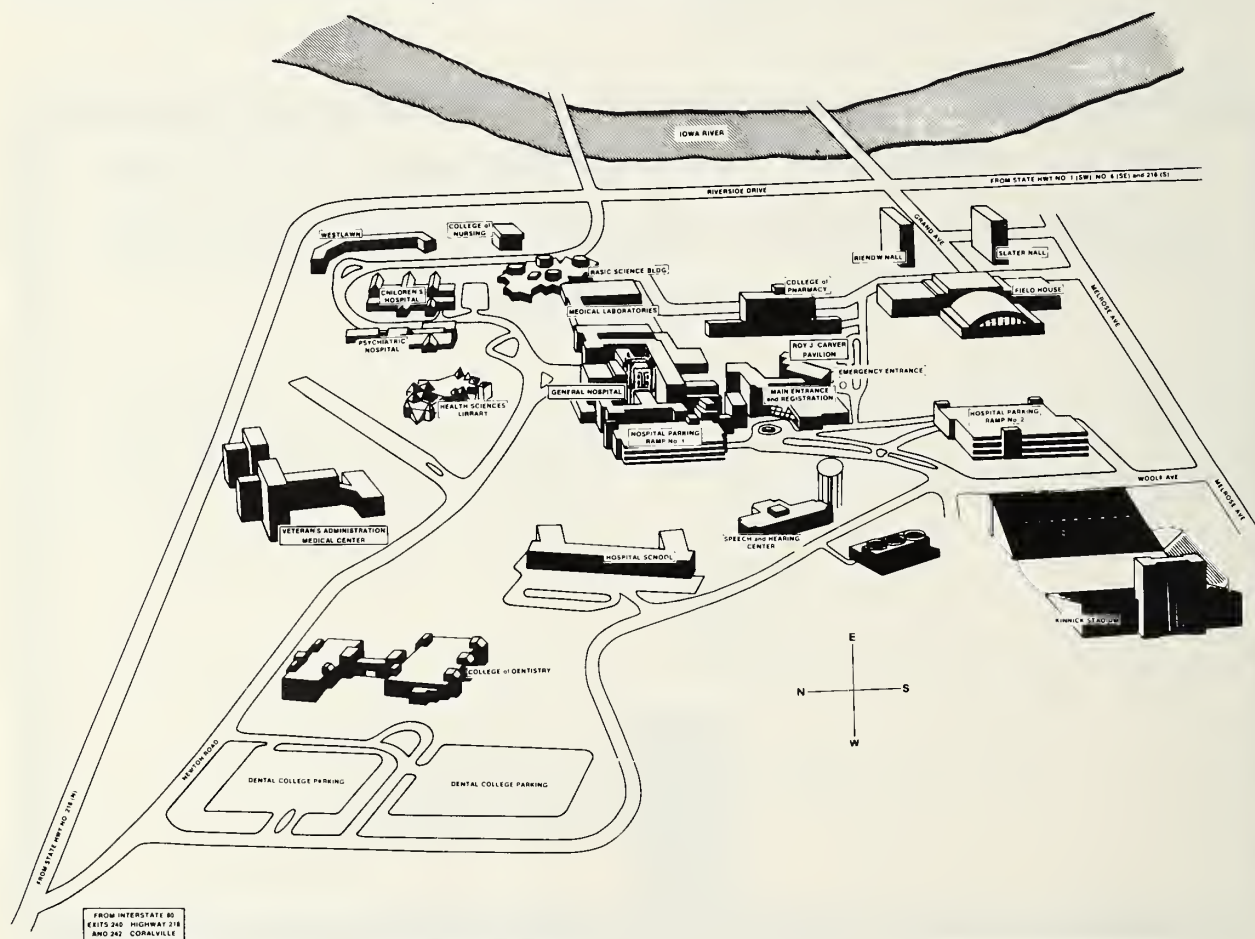
especially after the separation from a lifestyle of the 40-50 previous years, or the death of one's spouse.

I am sure that retirement is not for everyone. As long as one retains a fully capable mental and physical state, his talents should be utilized. This is more true in a profession, for wisdom and maturity of judgment come from experience rather than formal education. It is good that we have programs of continuing

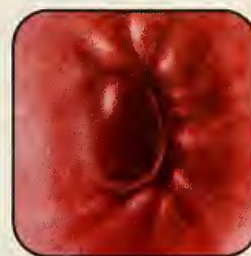
medical education so the older ones can gain from the education of the younger. Once the tedium ensues after long years of practice, and there are outlets for a continuing good and fruitful life, retirement can be considered. We have much to offer, though I would concede the long hours and the now-too-much paper work make retirement look attractive. The stresses of continuing crises are less tolerated than they were 20 years ago, but the challenges are still there with intrigue and enjoyment of fulfilling a need. For some, retirement can be enjoyed and tolerated early; for others, never. Time will tell regarding my ultimate decision. — M.E.A.

MORE RECENT MAP

The April issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY presented a special reference section entitled, "The University of Iowa Health Center Clinical Services Directory." An out-dated map of the U. of I. Health Center campus appeared on the concluding page of that section. The map shown here is current and is provided for reader information.



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Description: Each Anusol-HC Suppository contains hydrocortisone acetate, 10.0 mg; bismuth subgallate, 2.25%; bismuth resorcin compound, 1.75%; benzyl benzoate, 1.2%; Peruvion balsam, 1.8%; zinc oxide, 11.0%; also contains the following inactive ingredients: bismuth subiodide, calcium phosphate, and certified coloring in a hydrogenated vegetable oil base.

Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvion balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani. Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

Contraindications: Anusol-HC[®] Suppositories and Anusol-HC[®] Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnoses or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Core should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. One suppository in the morning

and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24); in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01); with plastic applicator, detachable label.

Store between 15°-30° C (59°-86° F.)

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HEALTH MAINTENANCE ORGANIZATIONS

In the Spring of 1970 the concept of health maintenance organizations (HMOs) was first introduced into legislation as an option under Part C of Medicare. Since that time there has been fervent public debate as to the advantages and disadvantages of such programs. The debate surrounding the development of HMOs focuses on the increased need to discover and initiate new methods of health care delivery systems that maximize the efficiency and quality of health care delivery.

The need for these new delivery systems is emphasized with statistics provided by the Department of Labor, Bureau of Labor Statistics. These statistics have shown that for all medical care in general, prices have risen 122.6% from 1967 to September, 1978. These are national figures based on the medical component of the Consumer Price Index.

The people of the State of Iowa are concerned with this problem of rising health care costs and recognize the need for revision or possibly replacement of parts of the health delivery system. In so recognizing this problem, the pros and cons of HMOs have been of great interest. I wish to briefly sketch out several of the issues which I feel are important when analyzing HMOs. I believe the evidence of the

last 8 years shows that public support of HMOs is well founded.

Since the beginning, prepaid health care has proven its advantages over less coordinated services. Many studies, private and public, have shown that members of HMOs use much less of the most expensive acute care, measured by hospital days, and have somewhat fewer office visits to a physician. The total bill for HMO members is lower while their "health" is just as good. The differences hold true for each age group studied, the elderly save as much as younger groups. Only children under 14 appear to use health care more in an HMO than the national average, making slightly more visits.

SAVINGS ELUSIVE

It is not possible to predict exactly how much money HMOs in Iowa would save, or how they would improve health care. There are many varieties of organizations and ways in which services are provided, each variation affecting the outcome. A rough estimate of the effect of establishing one HMO with 10,000 enrolled members can be calculated by looking at the use of hospital care that could be expected. All recent data is that HMO members have from 30-50% fewer days of care than a comparable population covered by other insurance. This translates into a difference of between one half and one million dollars spent on hospital care. This would not be all "savings" of course since some of this difference would be reallocated into prevention, detection and ambulatory services.

These statistics continue to prove the basic philosophy of health maintenance. Stated in a different way, costs are simply more visible

These remarks were presented by Health Commissioner Norman Pawlewski March 30, 1979 in Des Moines at a conference on the subject "Health Maintenance Organizations: Exploring Alternative Delivery Models."

and immediate in an HMO than with traditional insurance. Both providers and members must adjust their "consumption" to fit the budget established through capitation. Community rating allows members to share the risks of ill-health while each is more responsible for their own costs. The effects of over-utilization are felt very soon.

If the providers and members are aware of all the services available in an HMO, including screening, extensive diagnostic services, preventive and maintenance care, they will be guided to select the most cost effective care. The emphasis here is on effectiveness. Quality does not suffer if cost-consciousness is combined with prevention and early detection, as well as a judicious use of hospital services. The evidence is that HMOs have succeeded in instilling a consciousness of cost and the benefits of prevention, early detection and positive promotion of health.

HMOs were also proposed to offer a competitive element into a monopolistic industry. This has proven a more elusive goal. There is considerable debate, even at the federal level, whether more than one HMO should exist in a given health care market. Once an HMO is established in an area it is unlikely another will attempt to enter.

There have been some notable exceptions, such as Minneapolis, that indicate future trends toward more competition. The most visible and easily reached markets are now being tapped. With more experience, sub-markets and new ways to serve them will be developed. Thus, competition will be increased and the public's choices enhanced.

EXPERIENCE NEEDED

As we gain more experience, it will become easier to plan for and organize an HMO. It must be recognized that a great deal of time and effort must be expended in a feasibility study to establish an effective HMO.

Overall there does seem to be definite advantages to the establishment and utilization of HMOs. I do want to emphasize that although these advantages appear predominate and overshadow those of existing systems, we in Iowa don't see HMOs as a cure-all for all the problems of health care. Since there are none now existing in the State of Iowa it is hard to predict costs versus savings for our particular population and needs.

March 1979 Morbidity Report

Disease	Mor. 1979 Total	1979 to Date	1978 to Date	Most Mor. Cases Reported From These Counties
Amebiasis	13	26	56	Boone
Brucellosis	1	2	1	Dubuque
Chickenpox	1552	4125	2543	Scott
Cytomegalovirus	1	2	6	Polk
Eaton's Agent infection	4	21	64	Polk
Encepholitis, virol	1	4	2	Clinton
Erythema infectiosum	126	224	10	Scott, Pottowottomie, Story
Gastroenteritis (GIV)	2529	7258	10290	Scott
Giordiosis	3	10	6	Johnson, Boone Scott
Hepatitis, A	11	48	37	Polk, Story
Hepatitis, B	7	21	28	Polk
type unspecified	7	14	16	Scott
Herpes simplex	10	23	18	Johnson, Polk, Scott
Infectious mononucleosis	84	209	295	Winnebago, Linn
Influenza-like illness (URI)	12761	34456	32849	Scattered
Meningitis				
oseptic	3	12	0	Polk, Blockhowk
bacterial	9	30	18	Polk
meningococcol	1	4	5	Cerro Gordo
Mumps	56	110	67	Des Moines
Pertussis	0	0	2	NA
Robies in onimols	16	41	37	Corroll, Hordin, Morsholl, Mitchell
Rheumatic fever	4	6	11	Scattered
Rubello				
(German meosles)	39	41	14	Buchanon
Rubeolo (meosles)	1	2	9	Pottowottomie
Solmonello	18	38	34	Linn, Polk
Shigello	10	21	5	Scott
Tuberculosis				
total ill	6	23	28	Polk
bact. pos.	6	21	28	Polk
Venereol diseases:				
Gonorrheo	612	1550	1176	Scattered
P. & S. Syphilis	3	7	10	Polk, Scott, Linn

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Adenovirus — 1, Boone, 1, Winneshiek; Erysipelas — 1, Hordin, 1, Blockhowk; Scarlet Fever — 21, Scattered.

About IOWA Physicians

Dr. Thomas Thurman, Ottumwa, recently was elected a director of the First National Bank of Ottumwa. Dr. Thurman received the M.D. degree at U. of I. College of Medicine. Prior to joining Radiology Associates of Ottumwa, he was a clinical instructor at the University of Missouri — Kansas City School of Medicine. Dr. Thurman is president of the Wapello County Medical Society; secretary of Medical staff of Ottumwa and St. Joseph Hospitals; member of board of directors of Ottumwa YMCA; and a major in the U. S. Army Reserve Officers Association . . . **Dr. Wayne J. Tegler** has been elected president of Johnson County Medical Society. Other 1979 officers are **Dr. Robert C. Brown**, president-elect; and **Dr. Thomas B. Nicknish**, secretary-treasurer. All are Iowa City physicians. . . . **Dr. Leo V. Di-Cara**, Keokuk, has received the Physicians' Recognition Award from the American Medical Association.

Dr. John W. Herbst will join the Muscatine Health Center in July. Dr. Herbst is currently completing an internal medicine residency at U. of I. College of Medicine. . . . **Dr. Richard M. Caplan**, vice chairman of dermatology and associate dean of continuing medical education at U. of I. College of Medicine, was guest speaker at recent program on dermatology problems sponsored by the Keokuk Area Hospital. . . . **Dr. T. E. Shonka**, superintendent of the Mental Health Institute at Clarinda since 1976, has resigned effective April 30. Prior to becoming associated with the Clarinda institute, Dr. Shonka practiced in Malvern for 26 years. He and Mrs. Shonka plan to live in Red Oak. . . . **Drs. John Hoyt and Deepak Midha**, Creston, attended a recent seminar on coronary care in Omaha. The program was sponsored by Creighton University School of Medicine.

Dr. Dean L. McGinty will join the Muscatine Health Center staff in July. Dr. McGinty received the M.D. degree at U. of I. College of Medicine and is currently completing his family practice residency at the University of South Carolina School of Medicine. . . . **Dr. William M. Cannon**, Waterloo, was cited recently by the Hawkeye Chapter/American Red Cross for 20 years' service to the Hawkeye Regional Red Cross Blood Center. Dr. Cannon was presented a plaque, a sabre saw for his woodworking use, and a 20-year service pin. A senior pathologist at Schoitz Hospital, Dr. Cannon retired April 1. He and Mrs. Cannon are building a solar-heated retirement home on a mountainside in North Carolina. . . . **Dr. William R. Bliss**, Ames, spoke recently on voluntary hospital cost containment to the Mary Greeley Hospital Board of Trustees. . . . **Dr. Dennis A. Weis**, formerly of Oelwein, has joined **Drs. R. G. Tracy and C. J. LaTendresse** at the Family Health Center in Grundy Center. Dr. Weis received the M.D. degree at U. of I. College of Medicine; interned and served a family practice residency at the Methodist Medical Center in Peoria, Ill. . . . **Dr. K. V. Shah**, former clinical director of the Clarinda Mental Health Institute, has been named acting superintendent of the MHI. **Dr. T. E. Shonka** retired from this position on April 30. . . . **Dr. Edward J. Hertko**, Des Moines, was guest speaker at a recent meeting in Ames of the Cyclone County Unit of American Diabetes Association. Dr. Hertko is chief of staff at Iowa Methodist Medical Center in Des Moines and founder of a camp for diabetic children — Camp Hertko Hollow.

Dr. Jerry L. Jochims, Burlington, has been named a fellow of the American Academy of

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AIR FORCE. HEALTH CARE AT ITS BEST.

Orthopaedic Surgeons. . . **Dr. Ignacio V. Ponseti**, professor, Department of Orthopedic Surgery, U. of I. College of Medicine, was honored recently in Spain and England for research on congenital and developmental bone and joint disorders. While in Spain, Dr. Ponseti was visiting professor at the University of Madrid and received an honorary doctorate degree from the University of Barcelona. In England, he spoke to the British Orthopaedic Association of the Royal College of Surgeons. . . **Dr. Wayne E. Janda** recently joined the Independent Medical and Surgical Group in Mason City. Dr. Janda formerly was associated with the Park Clinic. . . **Dr. Robert C. Larimer**, Sioux City, was presented the American Society of Internal Medicine "Special Recognition" award at the ASIM annual meeting in New Orleans. Dr. Larimer was recognized for his service on the Health Insurance Benefits Committee and for continuing liaison with Blue Cross and Blue Shield and the Western Conference of Pre-Paid Medical Care Plans. . . **Dr. R. Bruce Dunker**, Mason City, recently gained

recertification from the American Board of Obstetrics and Gynecology.

Dr. Ming T. Tsuang, professor of psychiatry and preventive medicine at U. of I. College of Medicine, has received the Macy Faculty Scholar Award for 1979-1980. Dr. Tsuang will use the award to help support a one-year sabbatical at the University of Oxford in England beginning September 1. In addition to research, Dr. Tsuang will teach a course in psychiatric genetics at Oxford. . . **Dr. Edward R. Annis**, AMA past president, was guest speaker at an appreciation banquet honoring members of the medical and dental profession in the Keokuk area. The event was sponsored by the Keokuk Chamber of Commerce. A banquet was held March 23 to celebrate medical appreciation day as proclaimed by Keokuk Mayor C. F. Eppers. "In a day when people are criticizing health care and doctors, here is a town that recognizes, by golly, that it is fortunate to have these doctors," said William A. Castles, II, a spokesman for Keokuk Area Hospital.

DEATHS

Dr. Kenneth Lemon, 63, Oskaloosa physician, and his wife, Marjorie, died February 25 when their twin-engine light aircraft crashed into Tampa Bay, Florida, shortly after takeoff. Dr. Lemon received the M.D. degree and completed his residency in obstetrics and gynecology at U. of I. College of Medicine. He was a member of the Iowa Clinical Surgical Society; fellow of the American College of Obstetrics and Gynecology; chairman of the Oskaloosa Airport Commission; past member of the Oskaloosa School Board and City Council; and past president of the Mahaska County Hospital medical staff. During World War II, Dr. Lemon served as a major in the Medical Corps.

Dr. Daniel G. Bullock, 41, Ankeny, died at Iowa Lutheran Hospital on March 6. Dr. Bullock received the M.D. degree at U. of I. College of Medicine and interned at Broadlawns Hospital in Des Moines. He was a member of the Iowa Association of Pathologists; American Academy of Family Physicians; and Iowa Chapter of AAFP.

Dr. Martin T. Long, 28, Iowa City, died at his home on March 21. Dr. Long received the M.D. degree at U. of I. College of Medicine and was serving a residency in psychiatry at University Hospitals at the time of his death.

Dr. Charles M. Blackburn, 59, Ames, died March 25 at Mary Greeley Hospital. Dr. Blackburn received the M.D. degree at Duke Medical School in Durham, North Carolina, and served his internal medicine residency at the Mayo Clinic in Rochester, Minnesota. He joined the McFarland Clinic in Ames in 1964.

Dr. Warren Nash, 55, Waterloo, died March 27 at Allen Memorial Hospital. Dr. Nash received the M.D. degree at Creighton University School of Medicine in Omaha, Nebraska; and interned at St. Joseph's Hospital in Sioux City. He began his practice of medicine in Waterloo in 1954. During World War II, Dr. Nash served in the Navy with the Seventh Fleet in the Pacific. He was on the staff at Allen Memorial, St. Francis, and Schoitz Memorial Hospitals in Waterloo; past president of the Black Hawk County Branch of NAACP and recently was elected to the Board of the Afro-American Community Broadcasting Corporation.

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Medical Assistants



by **BETTY EHLERT, CMA-A**

INSTALLED IN APRIL

Nina Kline, CMA, LPN, was installed April 21 as 1979 president of the American Association of Medical Assistants, Iowa State Society, Inc. The new Iowa president has been an active member of the Black Hawk chapter since 1963. She was employed by Gardner Phelps, M.D., at that time. Since his retirement in 1970, Nina has attended the practical nursing program at Hawkeye Institute of Technology and was graduated in 1975. She is now a free lance assistant and works part-time for Cecil Seibert, M.D., Waterloo.

Nina is a certified CPR instructor and is active in this area. She works with various classes preparing people for emergency situations.

PRESIDENT'S MESSAGE

We have been progressing each year in our growth and our achievements, but we have an even bigger job looming ahead of us this year.

Through our educational activities, we are

She teaches adult education courses at Hawkeye Institute and serves on the advisory board of the school's medical clerical program.

A past president of the Black Hawk chapter, Nina was the 1976 convention co-chairman. She has also served as vice-president and budget and finance chairman. She has been a member of the state nominating committee and was treasurer two years. She has attended three national conventions. She passed her CMA in 1976 and is involved in the CEU program.

Nina's husband, Howard, is employed by Anderson-Erickson Dairy. They have two children and five grandchildren. Her main interests are her family, gardening, traveling and, of course, medical assistant.

able to do a better job technically. But we need always to establish our relationships with the patients to show sincere kindness and love. Demonstrating these qualities cannot replace education and knowledge. But they must be part of a medical assistant's personality, in addition to any and all professional qualifications.

We need to involve more of the new offices and the new doctors that are not familiar with our organization. We need the support of the doctors that are aware of our achievements so they can talk to the new physicians in Iowa. We encourage the assistants to come and see what our meetings have to offer. We want to help them grow and learn. A good medical assistant needs to have an open mind and an open heart always.

I am looking forward to the coming year as president of AAMA, Iowa State Society, Inc. Let's all work together for a great year. — **NINA KLINE, CMA, LPN**



Nina Kline

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Presidential Thoughts On IMS Representation

At the time of installation as president of the Iowa Medical Society last month I expressed a "... hope the Medical Society could be the bond to bring us together and the forum from which we can speak in one voice for the medical profession and its physicians in this state" — a call for unity that I do not believe can be overemphasized in these times.

Society is now well organized to regulate health care delivery. To effectively participate in this health care process, physicians, too, need to be organized. No specialties can expect to be exempted from the impact of regulatory changes. Within the fortnight alone, standards have been approved by the State Health Planning and Development Agency which will impact on the future practice of cardiologists, cardiac surgeons, radiologists, nephrologists, and family physicians, and two-thirds of the standards setting process is yet to come. Fortunately, the Iowa Medical Society staff was on deck to monitor and coordinate the physician expertise needed for the technical development of these standards. For the most part, the approved standards conformed to the criteria set forth by the Medical Society. In one area however, failure to get agree-

ment among members of a specialty group resulted in the submission of conflicting data and ultimately the loss of the majority position of the group.

I recognize physicians are inherently independent, self motivated people, not prone to compromise, but they are rational, and reason tells us we must settle our differences within and present a united front without.

The Iowa Medical Society, with its 2,800 members, is just short a few percentage points of representing all of the physicians in the state. A few new members and full participation by all members can make organized medicine and the medical profession in Iowa one and the same. Then the Iowa Medical Society can truly be the voice of Iowa medicine, and in the present social and political climate I assure you we will have many opportunities to speak.

Paul M. Seebohm M.D.

Paul M. Seebohm, M.D.

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IOWA Medical Miscellany

CHIROPRACTIC RULING . . . The Board of Chiropractic Examiners exceeded its bounds in the magnitude of its regulatory language, according to a recent ruling of the Attorney General's office. This decision squares with the contention of the IMS that the chiropractic examiners have sought regulatory authority beyond that allowed in the Iowa Code.

IMS BOARD . . . The first meeting of the IMS Board of Trustees under the chairmanship of Hormoz Rassekh, M.D., occurred May 30. Dr. Rassekh, a Council Bluffs psychiatrist, succeeds John H. Kelley, M.D., Des Moines, as chairman. Dr. Kelley remains on the board. L. W. Swanson, M.D., Mason City, has been appointed as IMS secretary for the coming year. He will fill the post held by W. R. Bliss, M.D., Ames, the president-elect.

OKAY OPTOMETRIC BILL . . . The Iowa Senate concurred May 1 with the House-passed version of an IMS-opposed bill to grant optometrists authority to use topical diagnostic agents. In a continuing effort to keep this language out of the Iowa Code, the Society has arranged a May 31 discussion with Governor Ray to underscore the inherent dangers. Governors in two states have vetoed similar bills.

ACTIVITY SIMILAR . . . Activity by the State Certificate of Need Council has run at about the same pace as its predecessor (1122 Council) body. Projects reviewed between July 1978 and May 1979 totalled \$105 million; a little over \$2 million in projects was disapproved.

REAPPOINTED . . . James German, D.O., Des Moines, and Ernest Theilen, M.D., Iowa City, have been given new three-year terms on the State Advanced Emergency Medical Care Council.

MMIS DISCUSSION . . . Pending implementation of the new Medicaid Management Information System was discussed in late April by IMS officials and Blue Cross/Blue Shield representatives. State adoption of MMIS is federally stimulated; increased administrative funding is available from HEW to states instituting MMIS. Main objective of MMIS is to provide increased accuracy and efficiency in claims handling. Use of the new Iowa Medicaid claim form will be possible July 1. From July 1 to September 1, both new and old claim forms will be accepted; after the latter date only the new form will be accepted. Of concern to the IMS has been (1) the distribution of, and (2) the need for completion of a "Non-Institutional Medicaid Provider Application." This application was circulated earlier in the year and has been described as necessary in establishing a provider file. Medicaid officials contend it is an application and not an agreement. Still to be answered is the question whether a current Medicaid provider will be excluded from reimbursement if he/she does not complete and return the new application.

POLIO MATTER . . . The appearance of polio among the Amish in Pennsylvania may be of interest to Iowa physicians inasmuch as there is some traffic between Amish citizens in this state and those in Pennsylvania.

MARIJUANA BILL PASSES . . . Legislation authorizing medical use of marijuana has been approved by the Iowa General Assembly. The measure sets up a research program and an advisory group of physicians through which it will be possible to provide marijuana to patients to help relieve pain. Rules applicable to the new law will be drawn and implemented by the Board of Pharmacy Examiners.

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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control

secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



The Question Box

by ERLING LARSON, JR., M.D.

AMA HOUSE OF DELEGATES

Erling Larson, M.D., is Iowa's senior delegate to the American Medical Association House of Delegates. Dr. Larson, a Davenport internist, comments here on issues scheduled for debate by the AMA House in July.

You'll be representing Iowa doctors in the AMA House of Delegates in July. What are the key subjects likely to be?

At least two subjects will command a major share of interest at the AMA meeting next month. Cost containment continues as the foremost problem haunting medicine at this time. It will receive great attention. The changing AMA stand on national health insurance will again be a key topic. As you know, the AMA backed away from a comprehensive cradle to grave program, and instead is concentrating on those areas in which there is weakness in the national coverage, and in particular in setting minimal standards for medical insurance. I believe with adoption of the new AMA recommendations almost all weaknesses in current insurance coverage, or lack of coverage, could be corrected.

Iowa has 3 delegates and 3 alternates. Do they all have a chance to get involved?

Iowa fortunately has 4 seats for its 3 delegates. The extra is a courtesy seat for Donovan Ward, a former AMA president from Iowa. He graciously allows us to use this seat to keep at least one alternate delegate seated with the regular delegates at all times. In addition, we

rotate the coverage of the 3 alternate delegates so all have a chance to participate in House affairs and vote on items with which they are well acquainted. In addition, the delegates and alternates caucus frequently to develop an Iowa stand on all major issues.

Is there any occasion where delegates from states with similar characteristics get together to consider various issues?

The State of Iowa is now in the process of meeting on the Saturday prior to the AMA convention with a new complex of states, with Missouri as the center. This group will consider issues only. In addition, we meet during the convention as a member of the North Central Medical Conference (Iowa, Minnesota, North Dakota, South Dakota and Nebraska) to discuss issues, legal problems and to hear candidates for AMA offices. These meetings are extremely helpful. The AMA House will consider several hundred items of business in its three-day meeting, and it is important for each delegate to cast an informed vote on each of them.

Do the Iowa delegates vote as a bloc or do they vote independently?

The Iowa delegation caucuses regularly and maintains constant communication during debate. To maximize the impact of a small delegation, we attempt to vote as a unit whenever feasible. None of us hesitate to vote independently when we feel our vote is in the best interest of Iowa physicians. Such independence has never created concern, either in the Iowa delegation or in the Iowa official family. It is a great honor to represent the physicians of Iowa, and all of the delegates and alternates feel an obligation to do their very best.

Presidential Remarks

Leading From Strength

RUSSELL S. GERARD, M.D.

Waterloo

Concluding his year as president of the Iowa Medical Society, Dr. Gerard submitted these summary remarks to the 1979 House of Delegates. He notes the healthy condition of the Society and emphasizes the continuing need for a united profession.

WE HAVE A TENDENCY to characterize every year as one of challenge and change. This really isn't too risky. For change, it seems, is an inevitable phenomenon. As for 1978/79, we have had a rather good ration of challenge and change.

The important subjects of health planning, cost of care, ancillary assistance and medical manpower have increased in their complexity over the past 12 months. We have sought to address these topics as thoughtfully and extensively as circumstances have allowed.

In the area of health planning, a main focus is on what acute hospital bed formula Iowa will use in the future. Last year the Iowa Health Systems Agency promulgated a 4.7 bed per 1,000 population guideline. Now, the Statewide Health Coordinating Council is devising new and more regulatory certificate of need criteria. Ultimately, this exercise may lead to the closing of some hospital beds. This can produce much consternation. We are making every effort to deal with this important matter realistically and objectively.

Dr. Gerard is in the private practice of general surgery in Waterloo, Iowa.

The appropriate use of the physician's assistant has provoked much discussion. We have around 100 PAs working in the state. Most of them are doing a good job.

COST OF CARE

As for the cost of care, President Carter and HEW Secretary Califano have challenged the nation's health care providers by calling for a cap on hospital costs. If this occurs, we know similar action is apt to follow for physicians. This issue of costs is probably our most critical. We are trying to meet it head on. Last year we were successful in reducing the level of increase in hospital charges by 2 percent. This was regarded as a significant accomplishment.

Our critics charge that the public is being taken for a ride on what has to be paid for health care. This is hard to comprehend compared with other segments of the economy. The money spent on automobiles exceeds that spent for personal medical care by 26 billion dollars a year. Doctors' fees? They don't come close to equaling what is spent to keep cars in running order.

The subject of medical manpower is a complicated one. Certainly, there is a need for more primary care physicians in Iowa. And we have made a noteworthy effort to alleviate the situation. Iowa has nine family practice programs with 170 residents expected to be involved totally this year.

Nationally, we have gained 80,000 doctors in the last decade. The country's 123 medical schools are producing 15,000 doctors per year. This is nearly double the figure of 10 years ago. The AMA has supported this full-scale effort to

(Please turn to page 230)

Inaugural Remarks

The Year of the Physician

PAUL M. SEEBOHM, M.D.

Iowa City

New IMS President Seebohm urges Society members to think of themselves as physicians first, specialists second. He discusses important licensure considerations and expresses alarm that some state examining boards have looked at licensing by medical specialty. He urges all specialties to close ranks.

BEING ELECTED to the office of President of the Iowa Medical Society is a special privilege. I humbly express to you my sincere gratitude for the confidence you have placed in me, being not unmindful of the heavy responsibilities associated with this office and knowing the coming year will bring both problems and opportunities for Iowa medicine.

In preparation for accepting this office, I looked up the duties of the President as they are prescribed in the Articles of Incorporation. Most of the stated duties consist of presiding over or attending meetings and the appointing of various committees.

The only other significant duty is that "the President shall be the *real head* of the profession of this State during his term of office." In a lot of ways this could be a major and precarious undertaking, were it not that a very high percentage of Iowa physicians hold membership in the IMS, thus qualifying the Society to speak for all but a few physicians in the State.

The term "real head," however, was more

perplexing. It implies there might be some other kind of head like an "unreal head" or a "figurehead." It also raises the question of who does head medicine. I have no illusions about the President of this Society ever being able to speak for all its members, but certainly there are no better spokesmen for medicine than physicians. Unfortunately, for some time now a lot of self-styled leaders outside the profession have tried to meddle with its destiny. Of all of these, the physician is the only one whose primary dedication and effort in life is to his patients as patients. Politicians and bureaucrats are concerned with medicine only because it relates to votes and budgets, and other social, economic and political forces. Physicians must continue to speak for medicine, and to accentuate their need to remain unfettered so as to provide the best treatment for their patients.

YEAR OF THE PHYSICIAN

As your "real head" of the profession, I would like to proclaim that my term of office be known as the "Year of the Physician."

All of us need to reaffirm *that* first and foremost we are physicians dedicated to the basic principles and ethics of medical practice. This means approaching our patients not only with a concern for their special complaints, but how these complaints impact on their health and life in general. We must be assured when multiple physicians and others are involved in care, there is in fact *a physician* in charge.

The taking of a good history is a skill all physicians need to master and keep fine-tuned no matter how highly specialized one's practice becomes, and there are many other aspects

Dr. Seebohm is executive associate dean of the College of Medicine at the University of Iowa.

(Please turn to page 226)

INAUGURAL REMARKS

(Continued from page 225)

of medical practice common to all specialties which characterize the physician from which we cannot disassociate ourselves because our practice has become highly specialized. I belabor this kind of "back to basics" philosophy for a number of professional and political reasons.

In the first place, the progressive sub-specialization in medicine which has developed exponentially in the past 30 years is fast peaking out. A revival of general internal medicine, general pediatrics, family practice and general surgery is tangible evidence of a turnaround. Even the super sub-specialization of many of the medical and surgical specialties has undergone a move toward creating a better balance between the generalist in these specialties and the subspecialist. In saying this, in no way do I wish to put specialists down. Specialization has been responsible for the great advances in medical care made in our time.

PHYSICIANS FIRST

I only ask that we all remember we belong to the same family. We are physicians first and specialists second.

Secondly, compared to the rest of the population, we are small, only $\frac{1}{10}$ of 1 percent of the population of Iowa. We need everyone of us. Nor can we afford to be splintered into factions within the ranks. The countersuits last year by the specialty societies over the chiropractic issue in Pennsylvania are cases in point. Had it not been for the untiring efforts of the AMA Board of Trustees, under the leadership of Doctor Hunter, to bring about a reconciliation at the AMA House of Delegates in December, this in-house squabble could have destroyed us all.

The specialties of our profession must close ranks. *Another basic principle* — divide and rule — is just as good a political ploy today as it was in the 15th Century when Machiavelli wrote it.

An infringement or attack on any of our specialties is the concern of all of us. When they come we need to close ranks and respond in one voice — the voice of the physician.

Thirdly, the licensure role of the states for

medical practice is being subjected to a number of attacks by those who would wish physicians to be licensed only by specialty. Interestingly enough, one of the first serious legislative moves was initiated by a group of physicians trying to abolish deceptive and misleading advertising in the yellow pages of the phone book. They ended up with a bill designed to license all physicians by specialty. Other efforts have evolved in health planning groups, particularly in California, looking to control the number of specialty training positions in a state. In this proposal, residents training in positions not certified by the state could not be licensed in the specialty in which they were trained. The licensure by specialty could have a horrendous impact on the freedoms of physicians, but even more importantly, on the quality of medical practice. The high standards for professional performance now set by the specialty boards would become the province of the state licensure boards and thus subjected to the whims of the political process.

DOMAIN OF MEDICINE

Fourthly, there are an increasing number of invasions into patient care, traditionally the domain of medicine. Even the legislature is working on bills to tell us what drugs to prescribe. We cannot allow medical care to be divided on the basis of the apparent severity of patient problems. Limited licensed practitioners need to have limited primary access to patients unless under the supervision of a physician. The severity of patients' conditions cannot be classified until they are *diagnosed*, and only the physician has the training, experience and competence to make that determination. We all know it is a much more sophisticated professional endeavor to certify a patient well than to declare him sick.

Fortunately, thanks to the past officers and the staff, our Iowa Medical Society enters this next year in an extraordinarily good condition.

In closing, I plead with the specialties to close ranks — the problems of any one of them is a problem for all of us. I would hope the Society could be the bond to bring us together and the forum from which we can speak in one voice for the medical profession and its physicians of this State.

Let us have a good year — "*The Year of the Physician.*"



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PRESIDENTIAL REMARKS

(Continued from page 224)

increase the number of physicians. We hear the experts comment on the excess number of physicians either now in or shortly to be in the work market. We hear that President Carter and Secretary Califano want to put a cap on the number of medical students. They contend each doctor who enters practice creates \$300,000 of medical costs his first year.

The administration, the public and the media need to be reminded continuously that medical costs have increased greatly in the past decade mainly because of demand and inflation. Progress in such new and high cost areas as renal dialysis and transplantation, coronary bypass surgery, chemotherapy, radiation therapy and body scanning have come with understandable stimulation from the public. Heavy use of hospital emergency rooms has increased the cost of care, as have premiums for liability insurance.

Yes, there has been an increase in the cost of health care, but the public needs to be reminded continuously that the best medicine in the world is practiced in the United States. Our trauma care saves more lives than in any other country. If we could but keep the intoxicated drivers off the road and reduce the accidents, we could do much more to curb health care costs than by putting a mandatory lid on hospital charges.

HELPING SMOKERS QUIT

Two-thirds of the nation's tobacco smokers report they have never received advice on quitting from their physicians. Studies indicate 9 out of 10 smokers know that smoking is a bad habit. They would like to quit, but do not know how. Perhaps many physicians do not know how to advise a patient how to quit smoking. Now there is help for the health professions.

The National Cancer Institute has developed

ALTERNATE DELIVERY SYSTEMS

We note much interest in Iowa in alternate types of medical care delivery. We are hearing about Individual Practice Associations and Health Maintenance Organizations. It is possible 4 Iowa cities will have IPAs or HMOs within 2 years. This will require adjustment by the medical profession.

We have a good peer review program. We can be proud of the Iowa Foundation for Medical Care.

As alluded to previously, one of our greatest problems is that of injuries and deaths caused by the automobile and the motorcycle. This is a huge problem. Nationally, highway accidents injure 50 million persons annually and cause 56,000 deaths. Highway accidents lead in cause of death for persons between the ages of one and 44. It is the fourth leading cause of death for all ages, following cancer, heart and infection.

We have made progress with many of our other challenges. There has been a reduction in malpractice insurance premiums. We have gone another year without total governmental control of medicine. The cost containment issue has seen some progress. We still must tackle it creatively and persistently.

The Iowa Medical Society, as an organization, is healthy from membership and financial perspectives. We have one of the highest membership percentages nationally. As we look to the future, we should emphasize the need for a united profession through the Iowa Medical Society and the American Medical Association.

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SCIENTIFIC ARTICLES

Outpatient Anesthesia

VICTORIA R. COBB-GERHART, M.D.,
JAMES G. CARTER, M.D., and
SAMIR D. GERGIS, M.D.
Iowa City

An overview of outpatient surgery and anesthesia is presented. Discussion includes advantages and disadvantages, patient selection and evaluation, a partial list of surgical procedures considered, discharge criteria and important physical aspects of a day surgery area.

IN THESE DAYS of soaring health care costs, any effort to reduce these amounts is obviously beneficial to all concerned individuals. Development of a day surgery or out-patient surgery program, such as a surgicenter, has been shown to reduce the expense associated with short surgical procedures. Consequently, the cost of hospitalization should decline, as should health insurance premiums. Day care surgery also tends to decrease the separation anxiety which is especially important for children. One final advantage to out-patient

surgery is the reduced incidence of hospital acquired infections. The inpatient infection incidence can be as high as 17%.¹

A wide variety of surgical procedures can be performed on an ambulatory basis with the mutual understanding and cooperation of all personnel involved. This approach frees more operating room time for in-patients who face more lengthy, difficult procedures. There are now a limited number of procedures done on this basis, but with the development of a good, efficient and professional team responsible for out-patient care, more procedures are becoming available for out-patient treatment. Such a program might involve the following partial list of surgical specialties and procedures for out-patient treatment:

1. General surgical procedures, such as pilonidal cysts, herniorrhaphies, breast biopsies, varicocoelectomies, removal of superficial masses, repair of lacerations and any other minor, uncomplicated procedures;

2. Pediatric procedures, such as inguinal herniorrhaphies, hydrocoelectomies, umbilical herniorrhaphies, rectal polypectomies and possibly circumcisions² (There is no general agreement concerning circumcision as out-patient surgery due to the possibility of bleeding problems.);

3. Orthopedic procedures, such as uncomplicated closed fractures, removal of ganglia,

Dr. Gerhart is an associate in Anesthesia, Dr. Carter is an assistant professor and Dr. Gergis is a professor in the Department of Anesthesia at the University of Iowa College of Medicine.

carpal tunnel releases and other minor hand procedures;

4. Otolaryngologic procedures, such as myringotomies and tubes, esophageal dilations and esophagoscopies, tracheal dilations, sinus washings, submucous resections, nasal polypectomies, caldwell lucs, nasal fractures, perhaps direct laryngoscopies with bronchoscopies and maybe even tonsillectomies, although there is no general agreement on the suitability of tonsillectomies and adenoidectomies as out-patient procedures;^{3, 4} (because of problems that may arise from bleeding).

5. Ophthalmologic procedures, such as exams under anesthesia, squints, lacrimal sac/duct procedures, cataracts, lid procedures and dermoid cysts;

6. Urologic procedures, such as cystoscopies, varicocoelectomies, vasectomies, urethral and bladder dilations, testicular and prostate biopsies, circumcisions,² meatotomies, some orchidopexys and hydrocoelelectomies;

7. Gynecologic procedures, such as dilatation and curettages, laparoscopies (both diagnostic and for tubal ligation), cervical conizations, vaginal biopsies, Bartholins cysts, removal of condylomata and exams under anesthesia;

8. Oral surgical procedures, such as tooth extractions, restorations, and some simple facial fractures;

9. Neurosurgical procedures, such as nerve and muscle biopsies;

10. Plastic surgical procedures, such as dermabrasions, steroid injections of scars, blepharoplasties, rhinoplasties, Z-plasties, augmentation mammoplasties, and some reconstructive surgery; and

11. Pain clinic procedures, such as selected diagnostic and therapeutic blocks including stellate ganglion, paravertebral, sciatic, ulnar, caudal, digital, ankle and epidural blocks.

Naturally, hospitalization must be available to these out-patients if complications arise such as: bleeding, profuse vomiting, prolonged recovery from anesthesia, or if the patient's condition warrants a more extensive surgical procedure than originally anticipated.

Patient selection is the key to an out-patient anesthetic practice. The primary point to remember is that day surgery is not to be regarded as inferior care. The surgeon is partially responsible for screening patients. In our

opinion, only healthy patients and those with mild asymptomatic systemic illness should be considered for day surgery.⁵ Evaluation of the patient should be done by the anesthesiologist in an anesthesia out-patient area. If there is no out-patient anesthesia clinic, the patient should be sent to the anesthesiologist in charge of out-patient surgery. This evaluation should be done well in advance of the actual surgery to allow ample time for review and further investigation of any abnormal laboratory results.⁴

The minimal data required prior to anesthesia would include a history of medical illnesses (review of systems), personal and family anesthetic history, medications, allergies, vital signs, examinations of heart, lungs, and other systems with pertinent findings from the history. Laboratory investigations should include urinalysis and hemogram. Any other pertinent laboratory tests should be ordered as indicated by the patient's history, e.g., serum electrolytes for patients on diuretics. An electrocardiogram should be obtained for patients older than 40 years and where otherwise indicated. The decision to obtain a chest X-ray is influenced by symptomatology presented by the patient and by his age. Patients older than 65 should have a chest X-ray to rule out silent carcinoma. Any patient with symptoms indicating chest disease should have a chest X-ray unless a recent film is available (within one year if there has not been any change in symptomatology). When the laboratory data collected is normal (or abnormalities are dealt with appropriately), the patient is presented for surgery. At this time, verbal and written instructions on the abstinence from food or drink for 6 to 8 hours prior to surgery are given. In addition, the patient should be informed that an adult must accompany him/her home after recovery from anesthesia. The patient should be warned that an acute illness would be a cause for cancellation of surgery and anesthesia due to the greater risk. Should an acute illness arise, the patient must communicate this information to the surgicenter the day before the scheduled surgery to allow for schedule rearrangement.

Upon arrival in the out-patient area, the patient should be dressed in hospital attire and settled into a reception area. At this time, re-evaluation of the patient is done by the anesthesiologist and pre-medication ordered. The reception area should be pleasant and parents

and/or companions should be allowed to stay with the patients until transfer to the holding area. Once in the holding area, the patient is given the pre-medication and an intravenous infusion is started, a sphygmomanometer cuff and electrocardiogram pads are applied and the patient is closely watched until transfer to the operating room. The nursing personnel in the holding area should be capable of handling any problems that may arise. If regional anesthesia is selected for surgery, it can be performed in this holding area to save time. After surgery the patient should be taken to a post-anesthesia recovery area, where he/she is allowed to awaken in a quiet, pleasant atmosphere until discharge. Here the patient should be reunited with his/her parents and/or companions.

The patient should maintain stable vital signs for a minimum of one hour. He or she should be orientated to person, place and time and should be able to perform simple psychomotor tests.³ The patient must prove that he/she has regained sensation following the procedure. Further, one should keep in mind it is essential to do what is right for the patient, not what is convenient for the personnel.

Other requisites for out-patient surgery include: (1) use should be limited to surgeons who work fast and can keep surgery and anesthesia time to a minimum; (2) the out-patient area should be staffed by efficient personnel to keep turn over time of the rooms to a minimum, and (3) the surgical schedule of the out-patient area should be finished by 3 p.m., at the latest, so patients will be assured of discharge before evening.

Finally, it should be noted that emergencies are difficult in an out-patient area because of the need to maintain tight schedules.³ With smooth admission and discharge procedures, rapid room turnover and maintenance of tight schedules, the use of an out-patient department will decrease health care costs and provide patients with a satisfactory setting for certain carefully-selected surgical procedures.

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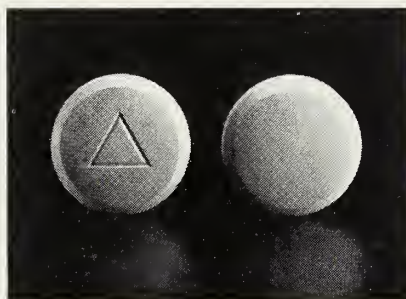
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The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.

PMA

Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

A Community Outbreak of Hepatitis A

J. R. McNIEL, M.D.
Fort Dodge

Hepatitis A moves mysteriously through four family members who live in different locations. Several theories are presented as to how the transmission occurred. Success was achieved in preventing a further outbreak.

THIS REPORT describes an outbreak of hepatitis A in a small, north central Iowa town. The outbreak centers around a family of four children, RJ, BJ, JJo and RJo. The mother of these children is mentally retarded and they reside in foster homes. RJ and BJ live with a family designated as Family 1, JJo lives with Family 2, and RJo is in a home for mentally retarded children.

THE PUZZLE

Near March 23, 1978, 5 of 7 family members became ill with acute viral hepatitis, later shown to be type A. Both parents had negative hepatitis B surface antigen (HB_sAg). Four of the 5 members recovered from the illness promptly and uneventfully. The other member, RJ, is one of two foster brothers (RJ and BJ mentioned above). His illness is summarized as follows:

RJ, a 12-year-old boy, developed a sore throat March 26, 1978. He consulted a physician who prescribed ampicillin, 250 mg 4 times a day. The following day he developed a fine erythematous maculopapular rash over the chest and abdomen. The ampicillin was discontinued, and he was given Erythrocin, erythromycin ethyl succinate, 200 mg, 4 times a day, which his mother gave for three and

one-half days. At that time jaundice appeared. Hepatitis B surface antigen test was negative April 3 and again on May 15. His initial serum glutamic oxaloacetic transaminase (SGOT) level on April 3 was reported over 1,000, and total bilirubin was 4.4 mg/dl. His bilirubin subsequently ranged from 8 to 10 mg/dl. The patient's jaundice persisted for 13 weeks, until July 8, when his bilirubin was 5 mg/dl. The patient was referred to Mayo Clinic on May 28 where a blood test for hepatitis A antigen was negative, and a blood test for hepatitis A antibody was positive.

Two individuals become ill. Five weeks later Mr. JS became ill with hepatitis. A few days later, near May 8, Mr. DD became ill. Mr. DD, a supervisor at a local meat packing plant, worked the week before becoming ill. However, he did not handle meat products. Both men had negative HB_sAg tests on May 15.

A second family outbreak of hepatitis occurs: (Family 2). On May 10 DL, a 9-year-old boy, became ill with fever 5 days followed by jaundice and an SGOT level of 596. One week after the onset of his illness, his mother developed a fever of 102 for 4 days with nausea, vomiting, and dark urine. JJo lives as a foster child with this family and is a half-brother of RJ of Family 1. JJo has a shunt in place for hydrocephalus. He vomited frequently near March 26 which was attributed to a blocking of his shunt, and his shunt was revised at University Hospitals in Iowa City on April 4. He received gamma globulin on May 30 when DL was diagnosed as having infectious hepatitis. His HB_sAg test was negative June 20, 1978. His SGOT was 848 on June 9. It gradually declined to 769 on June 16, 500 on July 8, and 96 on July 27. This child had a sub-clinical case of hepatitis without clinical illness suggesting hepatitis. The father of this family remained well and decided not to have

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SGOT determinations on himself, his 7-year-old girl, or his wife. The 7-year-old daughter was ill May 10 to 15 with abdominal pain.

A home for mentally retarded children becomes infected. In mid-June 3 children and 1 employee of a home for mentally retarded children in a nearby village became ill with hepatitis. RJo, a half-brother to RJ in Family 1 and brother to JJo in Family 2, is a resident of this home, and his room is next door to two of the children who became ill with hepatitis. RJo was not ill. His SGOT on June 9 was 30 (normals 6-26).

On June 25 TN, in another nearby town, became ill with prodromal symptoms of hepatitis. He became jaundiced on July 5.

The common source of infection in Family 1 is not known, but a visitor who stayed with the family February 3-8, on his way from a prison to another correctional institution, is a possible source. The two foster children of Family 1, RJ and BJ, visited with their natural mother, who is mentally retarded, and with their two half-brothers, RJo, of the home for mentally retarded, and JJo, of Family 2, every second and fourth Sunday of each month. A visit to this home in another town showed the level of hygiene and cleanliness to be very low. A flush toilet had been inoperative for 6 months.

A likely spread of the hepatitis was from Family 1 by way of RJ to his brother and half-brothers, who gave it to Family 2 and the home for mentally retarded children, either by infection of these brothers or by contamination.

A less definite pathway to JS would be by way of his child in school with BJ of Family 1. Mr. DD had two children in school, one with DL of Family 2 and one with RJ of Family 1.

The wife of Mr. RN was employed at the home for mentally retarded children. She received gamma globulin June 13 and again on July 6 and has remained well. There were no cases of hepatitis seen which could be traced to the meat packing plant.

Mr. TN was a member of a construction crew of 8 persons who shared a common drinking cup and common toilet facilities. All 8 had normal SGOT's on July 5, 1978, received gamma globulin, and have remained well.

This outbreak illustrates several interesting and important aspects of hepatitis A infection. The emphasis in the outbreak was on the identification and protection of susceptible persons with gamma globulin.

The period of communicability of hepatitis A

infection extends from about 2 weeks before the onset of prodromal symptoms to an indefinite time after transaminase levels have peaked and after immune electron microscopy fails to show virus particles in stool specimens.¹ In one case of experimental hepatitis A infection Dienhardt produced hepatitis in 4 of 6 marmosets using 47 day fecal samples.² This was three days after the peak in transaminase level, 6 days after the virus had ceased to be detectable by immune electron microscopy, and 4 days after the onset of jaundice.

Hall and Bradley, *et al*, found in a study of stool specimens from 28 hepatitis patients and 19 subclinical cases, the specimen with the highest concentration of virus was in a subclinical case of hepatitis two weeks after peak transaminase elevation.³ It was quite impressive to see JJo in Family 2 without any outward sign of illness and high transaminase levels, and realize he might be highly contagious.

Three weeks after her jaundice, the mother of Family 1 delivered a normal, healthy, term infant. Several measures were taken to protect this infant from infection, either by his mother or RJ. These measures included:

1. Giving gamma globulin in a dose of 0.1 ml/kg shortly after birth.

2. Advising the mother and child to move in with a grandmother in another residence until another home was found for RJ.

3. Prohibiting the mother from breast-feeding the infant. (Viremia occurs in hepatitis A¹ and breast-feeding might result in the ingestion of blood from a sore or cracked nipple.)

At 50 days of age the infant developed acute gastroenteritis. An SGOT determination was 44. There was no sign of hepatitis and she recovered promptly. At 12 months of age the child has shown no evidence of hepatitis. There has been no report of vertical transmission of hepatitis A (maternal-fetal).⁴ Although there was moderate morbidity associated with this outbreak, no deaths occurred. Since the clear separation of type A hepatitis from other types, it is now stated the mortality from hepatitis A is about 1 per 1,000 cases.⁴

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Hypothyroid Myopathy: An Unusual Elevation of Creatine Kinase

CHARLES DRISCOLL, M.D., and
JERALD R. SCHENKEN, M.D.

SLIGHT ELEVATIONS of the serum enzymes, lactic dehydrogenase, aspartate aminotransferase, and creatine kinase are encountered frequently in the course of hypothyroidism. Extremely high elevations are rare. Even serum amylase is increased in at least 50% of cases. This report concerns a patient in whom a dramatic change in serum enzymes occurred concomitantly with a clinically prominent myopathy.

CASE REPORT

A 58-year-old man was seen in the hospital emergency room after an episode of syncope at home. No recent illness was known. After backing his truck from his garage, he encountered weakness in the arms, dizziness, and was forced to sit down. A few moments later, his wife found him prostrate on the front porch. When aroused, he was dazed and confused. When he arrived at the hospital 20 minutes later, his sensorium was near normal. He denied chest pain or dyspnea.

Dr. Driscoll is an assistant professor in the Department of Family Practice at the U. of I. College of Medicine in Iowa City. Dr. Schenken is a professor in Department of Pathology at the University of Nebraska College of Medicine in Omaha.

Hypothyroid myopathy frequently causes elevations of serum enzymes which may be associated with clinical myopathy. A case report is presented on severe hypothyroidism and myopathy with markedly elevated serum creatine kinase. Demonstrated was an abnormal muscle biopsy showing waxy change, cytoplasmic vacuolization and some inflammation.

Past medical history included treatment for mild hypertension with Alphamethyldopa, 250 mg BID and hydroflumethiazide 50 mg daily for 7 years. Two remote prior hospitalizations were for tonsillectomy and adenoidectomy, and pneumonia. His mother had experienced an unclassified form of progressive muscular paralysis. No similar cases were described in his family. His father had diabetes mellitus.

Review of systems revealed progressive lethargy over the past months causing curtailment of outdoor activities including hunting with a bow and arrow. He noted muscular weakness and had difficulty arising from a squat. There were no chest, central nervous system, or gastrointestinal symptoms.

Physical examination revealed a jocular man, slow of speech with a husky voice. He was oriented to person and place but not to time. Temperature was 98.8° F., pulse 72 per minute, respiration 16 per minute, and blood

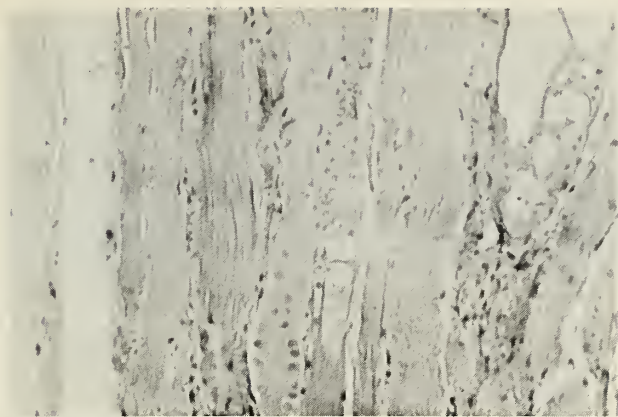


Figure 1. The muscle fibers vary in size and shape, some show a granular waxy change. Others contain cytoplasmic vacuoles. (150 ×)

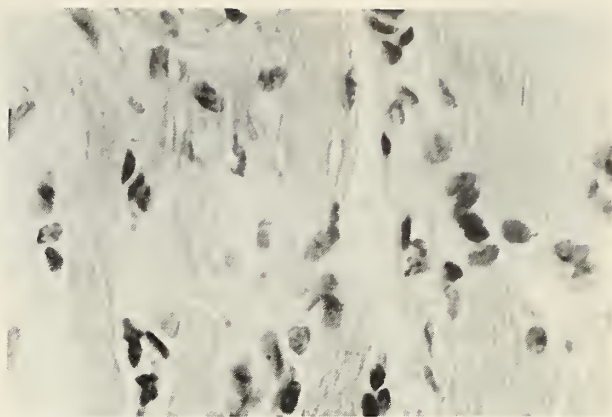


Figure 2. Muscle fibers showing fragmentation and infiltration by monocytes and lymphocytes.

pressure 120/70 mm of mercury. He weighed 195 pounds and appeared slightly obese. His facial skin was somewhat puffy. There appeared to be some loss of hair from the extremities but no edema was noted. Examination of the chest and abdomen was negative. There was no muscle hypertrophy, atrophy, or tenderness. On stooping, he was unable to stand without assisting himself with his hands. Neurological examination showed some depression of reflexes. Clinical diagnosis was myopathy of unknown etiology.

LABORATORY DATA

A CBC and urinalysis were within normal limits. Hemoglobin was 12.4 gm/dl and white count 6.3 thousand/mm³. Fasting and two-hour post-glucola^R blood glucoses were 84 and 107 mg/dl. His serum urea nitrogen was 15 mg/dl, creatinine 1.0 mg/dl, cholesterol 282 mg/dl, and triglycerides 186 mg/dl. Serum electrolytes were normal. His erythrocyte sedimentation rate was 64 mm Hg. Urine myoglobin was negative. Serial electrocardiograms for the first two hospital days were normal.

Total serum creatine kinase was 7,260 I.U. Serum thyroxine was 1.7 mcg/dl (N:4.5-11.5), T₃ resin uptake 30% (N:35-45%), and free thyroxine index 0.51 (N:1.58-5.18). Creatine kinase isoenzymes (performed two days later with the total creatine kinase at 2,565 I.U.) revealed MM band 96%, MB band 4% and BB band 0%.

CLINICAL COURSE

Because of the vague family history, the clinical myopathy and the elevated creatine

kinase, a biopsy of the left gastrocnemius muscle was performed 2 days after admission. Microscopic examination revealed significant variation in fiber size. Some fibers show homogeneous waxy change; others show large cytoplasmic vacuoles of varying sizes. (Figure 1.) Irregular eosinophilic nodular masses are noted in the sarcoplasm. The numbers of centrally-located nuclei are increased. Rarely, fibers are noted to undergo fragmentation and infiltration by mononuclear cells. (Figure 2.) Microscopic impression was myopathy, non-specific, severe.

Following admission the patient had no further episodes of dizziness although he remained tired. His blood pressure remained within normal limits. He was treated with 25 mcg of L-thyroxine per day gradually increasing the dose to 100 mcg per day. He continued to show marked clinical improvement with recovery of strength and endurance. Ten weeks following onset of therapy, his creatine kinase was 249 I.U. (N:< 50).

DISCUSSION

Marked elevations of creatine kinase in hypothyroidism are unusual but have been reported.¹ This patient's clinical onset, physical findings, in vitro thyroid function tests, response to L-thyroxine therapy, and muscle biopsy are all compatible with hypothyroid myopathy.

The origin of the raised serum creatine kinase in hypothyroidism is assumed generally to be from skeletal rather than cardiac muscle.^{2, 3} In most cases, only the MM isoenzyme

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Editorials

M. E. ALBERTS, M.D., Scientific Editor

CURING OR CARING

The cost of medical care is a popular subject for discussion among consumers, but more so among politicians. Proposals for lowering costs fly back and forth in the debates, but the full solution is difficult to develop. The primary problem lies in what constitutes medical service in the opinion of the provider, the patient and the fiscal third party. The concern I wish to consider is whether, as physicians, we are to care for our patients or just cure their ailments when possible — caring and/or curing.

A complaint often registered against the health professions is that it lacks concern. We are chastised for being in too much of a hurry with little or no time to talk to our patients, or to listen to them. We are accused of poor communication about the nature of their illness and our proposed plans of treatment. We are taken to task because of unavailability when the patient wants our services. There are valid rebut-

"A complaint often registered against the health professions is that it lacks concern."

tals to these points, but the question still arises about our image in the minds of our patients.

Governmental agencies complain of the cost of medical care in nursing homes and hospitals. Some would argue that many services are fringe benefits that are not necessary to the general well-being of the patient. Provision of occupational or creative therapy to the elderly is considered by some a waste of time, effort and money. Why, they ask, does a senile person who has suffered loss of mental awareness

need to be provided little handiwork projects. Do patients need private rooms with television, radio, electrically-operated beds and reading lamps? Must the meals served to the patients be of concern to the hospital administrator? I submit that when a person is the guest of a motel or hotel he does not share a room with a total stranger, nor does he seek the most inexpensive cafe to eat a meal. Being a patient in the hospital, or a nursing home, is a very

"Some aspects of medical care may be fringe niceties, but they are important for the well-being and recovery of the patient. The patient is a real person, not a machine put up for repairs."

personal and private affair, and certain niceties must go along with that, and they cost additional money. Some would argue that hospitals should be austere products of the building trade where a patient can be run through an assembly line to receive needed medical or surgical treatment in the most expeditious and inexpensive manner. Such persons imply callously that we should cure the patient without caring for his personal feelings.

True, waste cannot be condoned. We must care for our patients with a feeling other than cold professionalism. Let us be realistic; the politicians must be realistic. Some aspects of medical care may be fringe niceties, but they are important for the well-being and recovery of the patient. The patient is a real person; not a machine put up for repairs. If we have social progress, we must have social awareness. The patient deserves loving consideration, a pleasant atmosphere and comfortable surroundings, in addition, to excellent medical service. — M.E.A.

ABBREVIATIONS

The New Deal years of Franklin Roosevelt were noted for the frequent use of alphabetic designations. Numerous abbreviations were employed to denote various governmental agencies. Since those years more and more abbreviations have become part of our written and spoken language.

The medical profession has contributed to this trend. Many abbreviations have grown out of the numerous functions of our profession. A written history and physical report by a medical student is so replete with new and different abbreviations it may appear as a foreign language to some of us older physicians.

Accredited hospitals are required to maintain a reference source of all their approved abbreviations. Recently, one of the Des Moines hospitals issued a new listing of approved abbreviations — approximately 1,000 combinations of letters to denote words or phrases. It would appear some of the abbreviations are peculiar to the individual facility rather than part of any general usage. Some are confusing from the standpoint of having meanings dif-

ferent from what general non-professional use might imply.

For example, I thought "M&M's" were a popular candy, that "mph" denoted miles per hour, and "BS" referred to a specific barnyard substance. However, in this compendium of abbreviations, "M&M" is "milk and molasses," "mph" is minutes per hour, and "BS" is bowel sounds, or if written "B/S" it means breath sounds. If a British person were to read a history that started "the patient was taken to the hospital in a W/C," he would really wonder about those crazy Americans and their portable water closets.

I believe it is time for a turn-around in expressing ourselves. The English language can be written and spoken in a beautiful way without all the alphabet soup. Today's students have a difficult enough time expressing themselves in writing without compounding the problem with esoteric abbreviations. Most colleges and high schools no longer require essay answers to examinations; rather they use a check-off system compatible with a computer.

Let us return to the good use of language. Time is not so much a factor that we have to resort to such an abortion of word usage. — M.E.A. (*M. E. Alberts*)

HYPOTHYROID MYOPATHY: AN UNUSUAL ELEVATION OF CREATINE KINASE

(Continued from page 241)

could be identified. However, in 2 of 6 cases where high elevations of creatine kinase were reported, the patients with hypothyroidism showed traces of MB isoenzymes, as did our patient.¹ It is not clear at this time whether the finding of a trace of the MB fraction represents escape from skeletal muscle (noncardiac) because of markedly increased cell membrane permeability permitting faster rates of enzyme leakage or actual escape from cardiac muscle. Because the average total mass of cardiac mus-

cle amounts to little more than 1% of the total mass of skeletal muscle,² MB bands originating from cardiac muscle might be expected only when the total creatine kinase was markedly elevated, as in this case, if hypothyroidism affected both muscles equally. However, noncardiac skeletal muscle has been reported to contain small amounts of MB isoenzyme. As cardiac signs and symptoms are frequently present during the course of hypothyroidism and its treatment, the likelihood of cardiac involvement appears great.

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Educationally Speaking



by R. M. CAPLAN, M.D.

INCREASE THE BENEFIT

At a recent faculty retreat held by one of our larger departments I was pleased to hear the interest that the faculty members expressed in contributing to continuing education for the physicians of Iowa. Additional feedback makes me believe that spirit prevails in other departments as well.

Naturally, there was concern about the magnitude of requests for help in various educational efforts, both in the Iowa City area and elsewhere in the state. Since everyone's time and energy are precious, the faculty members at the retreat expressed clearly that they'd like to feel their continuing education efforts are really fruitful. Although it is one of medicine's revered traditions, an after-dinner talk at a medical society or staff meeting, all by itself, is not likely to be very fruitful. Many faculty have the idea, which I share, that a little more intensive effort given to the educational process, and a greater use of faculty skill applied to actual patient problems would pay off better

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

WELL REPRESENTED

Iowa medicine was well represented in a recent review of national developments within the medical specialties. This summary was

for you, the learner. It would also be more interesting and gratifying for the faculty.

I hope that, whenever the time and dollars are spent to bring a resource person to a community, maximum benefit could be had from that person's presence. For example, this might mean, in addition to one or two relatively formal or didactic presentations, an opportunity for seeing patients (either ambulatory or in-patient), perhaps a "grand rounds" type of session, perhaps an opportunity to review a recent or ongoing medical audit, or an opportunity to interact informally with questions or answers, or participate in problem-solving about actual patients or activities of the local scene.

I further hope that, along with requirements imposed upon us to spend certain hours in continuing education, we will respond maturely in order to assure truly productive value for that time spent. That means we must increasingly relate our educational time to the more important of the life problems that physicians face in their local settings. In that way we make time spent in continuing education more satisfying and fruitful for students and teachers alike.

presented in a special issue of the JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION (3/30/79) entitled Contempo.

Three of the specialty entries were written by members of the University of Iowa medical faculty: Anesthesiology — Jack Moyers, M.D.; Neurology — Maurice Van Allen, M.D., and Ophthalmology — Frederick C. Blodi, M.D.

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SCHOOL ASBESTOS PROGRAM

The Environmental Protection Agency (EPA) is initiating a nationwide information and technical assistance program to encourage states and school districts to identify and control exposure problems caused by asbestos-containing materials in school buildings. There are 3 reasons for EPA's concern: (1) asbestos-containing materials have been used extensively in buildings throughout the United States; (2) under certain circumstances asbestos fibers can be released from asbestos-containing materials into a building's air supply where they can be inhaled, and (3) because no one has ever established a safe or threshold level of exposure to asbestos, EPA believes any exposure increases a person's risk of developing lung cancer, mesothelioma, asbestosis, or other diseases.

There is generally a long latency period between exposure to asbestos and development of an asbestos-related disease. The length of the latency period depends on the amount and duration of exposure. The latency period may exceed 20 years, and people who are exposed to asbestos in school may develop asbestos-related diseases decades later. The longer a person is exposed, the greater are the chances of developing an asbestos-related disease.

The amount of asbestos which is released into a school's air depends on a number of factors, including the activities in the school. Indoor athletic activities, such as basketball games, may cause vibrations which cause the release of asbestos fiber. Capricious behavior by students may cause damage to asbestos-containing materials, and damaged material is

likely to release asbestos fibers. (Only friable asbestos-containing materials, materials that can be crumbled, pulverized, or reduced to powder in the hand, are likely to cause exposure problems.)

Friable asbestos-containing materials were used extensively in schools (and other buildings) for insulation and fireproofing from the end of World War II until 1973. Most of these materials were applied by spraying and are commonly referred to as sprayed asbestos materials. In 1973, EPA prohibited the spraying of friable asbestos-containing materials for insulation or fireproofing. This ban was extended in 1978 to cover spraying for nearly all uses.

The only sure way to determine whether a building contains friable asbestos-containing material is to visually inspect the building, take samples of the suspect material, and have the samples analyzed at a laboratory using polarized light microscopy. Building records do not always indicate whether asbestos-containing materials were used. Visual inspection alone is not adequate because some friable materials contain cellulose, glass fibers, or other fibers and look virtually identical to asbestos-containing materials.

In this program EPA has distributed a "guidance package" to school officials detailing methods and procedures for recognition and abatement of the problem. This agency will work with the Iowa Departments of Public Instruction, Health, Environmental Quality and the Bureau of Labor in a voluntary effort to reduce asbestos exposures in schools and, insofar as possible, provide technical assistance in containment/removal techniques. The guidance package, as well as other technical assistance on asbestos, is available to the public

STATE DEPARTMENT OF HEALTH

upon request from: Mr. Wolfgang Brandner, EPA Region VII, 324 East 11th Street, Room 1500, Kansas City, Missouri 64106 — Telephone (816) 374-3036, Toll-free number: 800-821-3714.

MEDICAL MISCELLANY

SHCC ACTIONS . . . The Statewide Health Coordinating Council took action May 9 to approve standards for (1) acute care bed needs, (2) computerized tomography, (3) end stage renal disease, and (4) cardiac catheterization and cardiovascular surgery. Joint efforts by the IMS and Iowa Hospital Association produced methodology for the acute care standards which are much superior to earlier proposals. Nonetheless, Society concern still exists over possible interference with appropriate medical

Other general assistance or inquiries on school based asbestos problems is available from: Russell W. Currier, D.V.M., Chief, Division of Disease Prevention, Iowa State Department of Health, Lucas State Office Building, Des Moines, Iowa 50319 — Telephone (515) 281-5643. — *Adapted from Federal Register 3/23/79*

utilization of hospital facilities as a result of bed reductions. Additional and significant IMS concern exists over the failure to accept medical input during development of the CT standards. This disregard of IMS expertise may jeopardize the new and improved quality of care made possible by the use of this technology. Society suggestions in the other areas were accepted for the most part by state staff and adopted by the SHCC.

FOUNDATION MOVES . . . Offices of the Iowa Foundation for Medical Care have been moved to the Colony Park Office Building, 3737 Woodland, Suite 500, West Des Moines 50265.

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April 1979 Morbidity Report

Disease	April 1979 Total	1979 to Date	1978 to Date	Most April Cases Reported From These Counties
Amebiasis	12	39	59	Boone
Brucellosis	0	2	8	—
Chickenpox	1128	5253	3492	Scattered
Cytomegalovirus	0	2	11	—
Eaton's Agent infection	2	24	68	Poweshiek, Union
Encephalitis, virol	1	5	3	Clinton
Erythema infectiosum	259	483	33	Scattered
Gastroenteritis (GIV)	1296	8554	11396	Scattered
Giardiasis	2	12	10	Scott, Des Moines
Hepatitis, A	12	60	55	Polk
Hepatitis, B	8	29	37	Johnson, Polk
type unspecified	3	17	25	Scott
Herpes simplex	3	26	27	Johnson, Polk
Infectious mononucleosis	36	254	426	Block Hawk, Linn, Polk, Morsholl
Influenza-like illness (URI)	3812	38268	35704	Scattered
Meningitis oseptic	0	12	0	—
bacterial	13	43	20	Decatur, Linn, Scott
meningococcal	1	5	7	Cloyton
Mumps	67	177	92	Des Moines, Kossuth, Johnson, Dubuque
Pertussis	1	1	0	Winneshie
Robies in animals	17	58	47	Shelby, Hancock
Rheumatic fever	2	8	18	Lee
Rubella (German measles)	2	43	19	Linn
Rubeola (measles)	5	7	20	Block Hawk, Bremer, Dollos
Solomonello	8	46	45	Block Hawk
Shigella	3	24	7	Scott
Tuberculosis total ill	7	30	39	Muscotone, Block Hawk, Polk,
bact. pos.	7	28	29	Pottowottomie, Win- nebago, Worth
Venereal diseases: Gonorrhea	383	1933	1698	Scattered
P. & S. Syphilis	11	18	14	Johnson, Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Scarlet Fever — 13, scattered; Guillain Barre' Syndrome — 1, Scott, 1, Dubuque; Legionnaire's Disease — 1, Block Hawk, 1, Mohosko, 1 Tomo; Reye Syndrome — 1, Woodbury.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

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References: 1. Citations available on request — Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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About IOWA Physicians

NEW DOCTORS IN IOWA

Dr. Michael Berstler will join the Rohlf Memorial Clinic in Waverly in July. A native of Fort Madison, Dr. Berstler received the M.D. degree at the University of Kansas Medical School in Kansas City, Missouri, and had his family practice residency in Davenport. . . .

Dr. Paul Knouf will join the McCrary-Rost Clinic in Lake City in August. Dr. Knouf received the M.D. degree at U. of I. College of Medicine and had his family practice residency in Des Moines. . . .

Dr. Jim McCabe will join the Buena Vista Clinic in Storm Lake in August. Dr. McCabe received the M.D. degree at U. of I. College of Medicine and had his family practice residency in Sioux City. . . .

Dr. Robert G. Good joined Osceola's Clarke Medical Clinic in April. Dr. Good graduated with distinction from the College of Osteopathic Medicine and Surgery in Des Moines and interned at Sun Coast Hospital in Largo, Florida. . . . **Dr. Duane Wilkins**, former Maquoketa family physician, will begin private practice of surgery in Maquoketa in July. Dr. Wilkins left his FP practice three years ago to do a surgical residency.

Dr. Thomas Foley, Marshalltown, was honored recently for his "outstanding service" to the Central Iowa Emergency Medical Services Council, a coordinating agency for emergency medical services in a 21-county area. The award was presented to Dr. Foley during the Council's first annual conference in Des Moines. Dr. Foley has served as medical director of the Council since June, 1978. . . . Two faculty members from the U. of I. Department of Internal Medicine, **Dr. Richard M. Freeman**,

professor of medicine and director of hemodialysis, and **Dr. Carl Richards**, assistant professor of medicine, spoke at a recent Keokuk Area Hospital seminar on evaluation and management of acute and chronic renal failure. . . . **Dr. David E. Dennis** has been named president of the Franklin General Hospital medical staff; **Dr. Dorothy Heuermann**, vice president; and **Dr. Wayne Sands**, Des Moines, secretary. . . . **Dr. Arthuro P. Mirasol**, of Youngstown, Ohio, will become Shelby's first physician in six years. In July, Dr. Mirasol will reopen the Shelby Medical Clinic, which has been closed since 1973. He received his medical education at the Far Eastern University Medical School and has been a surgical resident in Youngstown for the past three years. . . . **Dr. Ronald Lauer**, vice chairman of the U. of I. Department of Pediatrics, was guest speaker at a recent meeting of the Fort Dodge Arrowhead Area Education Agency. Dr. Lauer spoke on "Coronary Risk Factors in School Age Children."

Dr. Oscar C. Beasley, Iowa City, has been named president of the Mercy Hospital medical staff. Other officers are — **Drs. Lowell A. Luhman**, president-elect; **James L. Skarda**, secretary-treasurer; and **Robert D. Whinery**, past president. All are Iowa City physicians. . . . **Dr. James Maroc** has been named director of the Williamsburg Family Practice office. Dr. Maroc received the M.D. degree at the Indiana University School of Medicine. Prior to locating in Iowa, he was in private practice in Hammond and Munster, Indiana. . . . **Dr. William M. Jagiello** has joined the Clinic of General Medicine in Des Moines. Dr. Jagiello received his medical education at College of Osteopathic Medicine and Surgery in Des Moines and completed his family practice resi-

dency at Lutheran Medical Center in St. Louis, Missouri. . . . **Dr. Albert E. Montgomery**, Estherville physician since 1967, recently retired from his internal medicine practice. Prior to locating in Estherville, Dr. Montgomery served 25 years in the U.S. Army Medical Corps. He plans to continue living in Estherville and will spend his winters in Florida.

Dr. Paul M. Schollmeier will join the Buffalo Center Medical Center in August. Dr. Schollmeier received the M.D. degree at the University of Minnesota Medical School and served his family practice residency at Fairview-St. Mary's Hospitals in Minnesota. He will combine his Iowa practice with an additional practice at Blue Earth Medical Center in Minnesota. . . . **Dr. James T. Worrell**, Keosauqua, was named by the Van Buren county board of supervisors to complete an unexpired term on the county board of health created by the resignation of **Dr. Ira Christy**, Farmington. . . . **Dr. Terry F. Dynes**, Decorah, recently conducted a program for area resi-

dents who are on low salt diets or who cook for people with salt modification needs.

Four U. of I. faculty participated in the recent Third International Symposium on Plastic and Reconstructive Surgery of the Head and Neck in New Orleans. **Dr. Janusz Bardach**, a visiting professor in the Department of Otolaryngology and Maxillofacial Surgery, discussed reconstructive procedures in the head and neck and presented a paper on "Influence of Cleft and Palate Repair on Facial Growth: Experimental Study in Rabbits." **Dr. William R. Panje**, director of head and neck surgical oncology in the Department of Otolaryngology, conducted a course on "Microsurgical Reconstruction of Soft Tissues and Anterior Mandibular Defects," and presented a paper on "Compound Trapezius Flap for Reconstruction of Head and Neck Defects." **Dr. Richard L. Anderson**, director of oculoplastic service at U. of I. and chief of ophthalmology at Iowa City VA Hospital, presented a paper on "Myocutaneous Flap for Major Eyelid and Canthal Reconstruction." **Dr. Roger I. Ceilley**, assistant professor in the Department of Dermatology, presented a paper on "Microscopically Controlled Excision of Malignancies of the External Ear Followed by Surgical Reconstruction." The symposium was sponsored by the American Academy of Facial Plastic and Reconstructive Surgery with the American Society for Dermatologic Surgery and the American College of Chemosurgery. . . . **Dr. Glen Gabrielson**, Mt. Pleasant, plans to relocate in Fort Madison this summer. Dr. Gabrielson received the M.D. degree at U. of I. College of Medicine and completed his family practice residency at University Hospitals in Iowa City. He began his family practice at Mt. Pleasant in July 1978.

Dr. Wing-Tai Fung, Harlan, was a recent guest speaker at the Shelby-Tennant Community School. Dr. Fung discussed his Chinese family and schooling; his decision to become a doctor; and his education in Hong Kong and in America. . . . **Dr. Joseph Callaghan**, Decorah, has cancelled his plans to take a fellowship in reconstructive plastic and hand surgery at the Mayo Clinic in Rochester, Minnesota, and will continue his general surgery practice in De-

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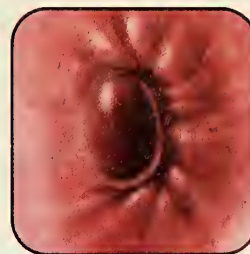
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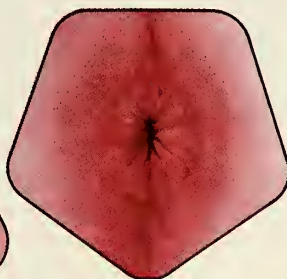
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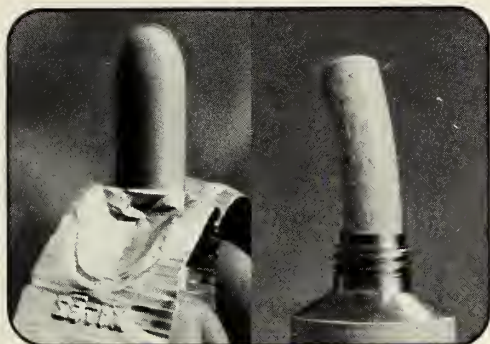
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Each gram of Anusol-HC Cream contains hydrocortisone acetate, 5.0 mg; bismuth subgallate, 22.5 mg; bismuth resorcin compound, 17.5 mg; benzyl benzoate, 12.0 mg; Peruvian balsam, 18.0 mg; zinc oxide, 110.0 mg; also contains the following inactive ingredients: propylene glycol, bismuth subiodide, propylparaben, methylparaben, polysorbate 60 and sorbitan monostearate in a water-miscible base of mineral oil, glyceryl stearate and water.

Indications: Anusol-HC Suppositories and Anusol-HC Cream are adjunctive therapy for the symptomatic relief of pain and discomfort in: external and internal hemorrhoids, proctitis, papillitis, cryptitis, anal fissures, incomplete fistulas and relief of local pain and discomfort following anorectal surgery.

Anusol-HC Cream is also indicated for pruritus ani. Anusol-HC is especially indicated when inflammation is present. After acute symptoms subside, most patients can be maintained on regular Anusol[®] Suppositories or Ointment.

Contraindications: Anusol-HC[®] Suppositories and Anusol-HC[®] Cream are contraindicated in those patients with a history of hypersensitivity to any of the components of the preparation.

Warnings: The safe use of topical steroids during pregnancy has not been fully established. Therefore, during pregnancy, they should not be used unnecessarily on extensive areas, in large amounts, or for prolonged periods of time.

Precautions: Symptomatic relief should not delay definitive diagnosis or treatment. If irritation develops, Anusol-HC Suppositories and Anusol-HC Cream should be discontinued and appropriate therapy instituted.

In the presence of an infection the use of an appropriate antifungal or antibacterial agent should be instituted. If a favorable response does not occur promptly, the corticosteroid should be discontinued until the infection has been adequately controlled.

Core should be taken when using the corticosteroid hydrocortisone acetate in children and infants.

Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. One suppository in the morning

and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

NOTE: If staining from either of the above products occurs, the stain may be removed from fabric by hand or machine washing with household detergent.

How Supplied: Anusol-HC Suppositories—boxes of 12 (N 0047-0089-12) and 24 (N 0047-0089-24); in silver foil strips with Anusol-HC W/C printed in black.

Anusol-HC Cream—one-ounce tube (N 0047-0090-01), with plastic applicator, detachable label.

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corah. At the March meeting of the Wright County Medical Society, **Dr. Ronald J. Ziance**, pharmacologist at Smith, Kline and French Laboratories, gave a presentation on the "Diagnosis and Treatment of Anaerobic Infections." . . . **Dr. Joseph J. Heller**, Dubuque, has been named chief of staff at the Mercy Medical Center. . . . **Drs. Fred and Eva Abbo**, Cedar Rapids internists, closed their local practice in May and will relocate in La Jolla, California. Dr. Fred Abbo has practiced in CR for 11 years and his wife, Eva, for 7 years. . . . **Dr. Frederick K. Chapler**, professor of obstetrics and gynecology at the U. of I., was guest speaker at recent meeting of the Woodbury Medical Society. Dr. Chapler spoke on "Estrogen Replacement: A Changing Problem."

Dr. Dwayne E. Howard has been named president of the medical staff at St. Luke's Medical Center in Sioux City. Other officers are — **Dr. Lee W. Van Voorhis**, vice president; and **Dr. John H. Roberts**, secretary-treasurer. All are Sioux City physicians. . . . **Dr. Kim P. Petersen**, Newton, was guest speaker at the spring meeting of the Skiff Hospital Auxiliary.

Dr. Petersen's topic, "Preventive Medicine — How to Feel Better, Save Money and Avoid the Doctor." . . . **Dr. G. M. Paluska** has resigned from the medical staff at the Gilfillan Clinic in Bloomfield. Dr. Paluska, a pediatrician, joined the Gilfillan Clinic in 1976. . . . **Dr. Gerald F. DiBona**, professor in the Department of Internal Medicine at U. of I. College of Medicine, has been named president of the American Federation of Clinical Research. Since 1973, Dr. DiBona has served as a national councilor and has testified before the U. S. Senate Subcommittee on Health and Scientific Research for the clinical research group and the Association of American Medical Colleges. . . . **Dr. A. S. Owca**, Centerville, discussed losing weight at recent meeting of District 9 TOPS (Take Off Pounds Sensibly) group. Over 300 members attended the Centerville meeting.

DEATHS

Dr. John B. Dressler, 67, Ida Grove, died April 3 at his home. Dr. Dressler received the M.D. degree at University of Nebraska Medical School and began his medical practice in Ida Grove in 1939, retiring in 1978. A fellow of the American Academy of Family Practice, Dr. Dressler was a past president of the Ida Grove School Board and served for several years as Ida County medical examiner.

Dr. Chetwind M. Franchere, 86, long-time Mason City physician, died April 10 at a Mason City nursing home. Dr. Franchere received the M.D. degree at the University of Illinois College of Medicine and located in Mason City in the early 1920s. A veteran of World War I, he served as city health officer for many years and past secretary of Cerro Gordo County Medical Society. A long-time staff member at St. Joseph's Mercy Hospital, Dr. Franchere was a life member of the Iowa Medical Society.

Dr. John W. Thornton, 87, long-time Lansing physician, died April 17 at St. Francis Hospital in LaCrosse, Wisconsin. Dr. Thornton received the M.D. degree at Rush Medical College in Chicago. He began his medical practice in Lansing in 1917, assisting his father, Dr. John H. Thornton, and retired from active practice in 1974. Dr. Thornton was a life member of the Iowa Medical Society.



PRESIDENTIAL ASSESSMENT OF BRITISH NHS

On a recent trip to France and England, I was impressed by the preoccupation of radio, T.V. and newspapers with problems of the National Health Service (NHS) in England. My awareness began with a statement on the BBC radio broadcast in Paris by the newly elected Conservative Party to "restore the *vitality* of the National Health Service." Later in London with full access to the media in English, I received multiple reports on T.V. and in the newspapers about the growing impact of the private sector of medicine on the NHS. When the old Labor Party decided to phase out private beds in NHS hospitals the number fell to 2,800 nationally. This stimulated the utilization of separate private hospitals and requests for health planning approval of construction of more private beds! Private medical insurance is also booming, growing at a rate of 8-10 percent a year and now covering over 2.5 million people.

The reasons for the shift of the public toward private care are (1) the long NHS waiting lines for non-emergency cases, (2) a slight easing in people's budgets and (3) a general increase in health consciousness among the British citizenry.

It is possible the private sector of the American health care system has been somewhat uneven in its growth and development; but after 30 years, instead of enjoying the efficiency of a fine-tuned government enterprise,

the centrally planned NHS British system is coming apart at the seams.

Our patients still have a choice and we as physicians need to see they keep this privilege. Foreign experiments at regimentation have not been accepted as particularly good models for American medical care, except to demonstrate the stifling effect of rigid systems on creativity and adaptability to social and scientific change. We must strive to keep American medicine "loose," opposing plans that put fixed boundaries around facilities, professionals and services.

In no way do I intend this statement to impugn the current efforts of our Society through the HSA and PSRO to provide a guide for the orderly utilization and planning of our health resources, but I believe they should be just that — a guide for the operation and growth of the health care system, not an administrative box of protocols and quotas. Physician participation in health planning activities must be continued. Only with our presence can we balance the forces that will impinge on the style of medical practice and patient care in this country, so we do not repeat the history of failure of the British NHS.

Paul M. Seebohm M.D.

Paul M. Seebohm, M.D.

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JOURNAL OF THE

IOWA medical society

VOL. 69, No. 7

JULY 1979

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Address all communications to the Editor of the Journal,
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IOWA Medical Miscellany

GOOD NEWS . . . Society participants in the IMS/Aetna Liability Insurance program will divide \$240,329 in August or September. This early dividend for the 1978 account year will average 7.6% of premium; the average will vary depending on classification. A dividend of \$334,382 was paid earlier this year.

TITLE XIX CLAIM FORM . . . Beginning this month a new Medicaid claim form is available for use. The form is part of the current implementation of the Medicaid Management Information System. The new and old claim forms will be accepted until September 1 when the new one will be used exclusively.

NEW TRANSPORT SYSTEM . . . A new 24-hour helicopter transport service will become operational in Des Moines this summer. The service is named Life Flight, and is intended to serve the central Iowa area. The helicopter will be ported at the Iowa Methodist Medical Center, but patients may be flown to any Des Moines hospital. The copter will accommodate two patients, two medical attendants and a full range of medical equipment for critical care.

SET '80 SPORTS CONFAB . . . Planning has begun for the fifth in a series of every-other-year meetings on the medical aspects of sports. This popular event for coaches, physicians, etc., is sponsored by the IMS and the Iowa High School Athletic Association. The 1980 conference will be March 27 in the Olmsted Center at Drake University. Donald Cooper, M.D., team physician at Oklahoma State, will be the keynote speaker.

1979/80 DIRECTORY . . . Preparations for the 1979/80 IMS Membership Directory are underway. Further improvement in the publication is planned. To be continued for a second year will be the opportunity for interested physicians, clinics, etc., to include separate informational messages. A mailing inviting such participation has been sent to all members.

AMA HOUSE . . . Iowa's delegates and alternates to the American Medical Association will be in Chicago July 21 to 26 to participate in the policy-making activities of the AMA House of Delegates.

U. OF I. REP . . . With financial assistance from the IMS, Jerry Wedemeyer will attend the 1979 AMA session in Chicago, and participate particularly in the affairs of the Student Business Section. Wedemeyer, a senior, also will have opportunity to join in on caucuses of the IMS delegation.

LOOKING AHEAD . . . Already thoughts have turned to the 1980 IMS Scientific Session scheduled April 16-18 in Iowa City. Chairman of the 1980 Program Committee is Roy Pitkin, M.D., Iowa City. Assisting him will be George Baker, M.D., Richard Caplan, M.D., and Christian Schrock, M.D., all of Iowa City; John MacGregor, M.D., Mason City, and Charles Waterbury, M.D., Waterloo.

EXECUTE ARTICLES . . . Appropriate IMS officers have signed a document to be filed with the Iowa Secretary of State as part of the process involved in executing the Society's revised Articles of Incorporation which were approved recently by the 1979 House of Delegates.

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The Question Box

by JOHN W. ECKSTEIN, M.D.

THE AMERICAN HEART ASSOCIATION — ITS WORK, SCOPE, AND RESULTS

Dr. Eckstein is professor of internal medicine and dean, University of Iowa College of Medicine. He is currently president of the American Heart Association.

How would you describe the principal goals of the American Heart Association?

Very briefly, the American Heart Association exists to help reduce premature death and disability resulting from heart attack and cardiovascular disorders.

Specifically, the current AHA goals are: 1) to reduce the prevalence of uncontrolled high blood pressure; 2) to increase the availability, utilization and quality of emergency cardiac care; 3) to increase the extent and excellence of cardiac rehabilitation services; 4) to increase the availability and effectiveness of acute and rehabilitative care for stroke patients; 5) to influence youth to develop behavior patterns which will improve their cardiovascular health throughout life; and to influence Americans to modify 6) their dietary habits to conform with AHA recommendations, and 7) their cigarette smoking habits.

What progress is being made in achieving these goals?

Since 1950 the death rate for hypertension has fallen by about 90%. In that same period the rates for rheumatic fever and rheumatic heart disease declined by about 65%, and the mortality rate for coronary heart disease by more than 8%.

Combined, this translates into an overall reduction of more than 30% in the mortality rate for all cardiovascular diseases over the past generation. This year 80,000 Americans will survive heart attacks which would previously have been fatal to them.

Could you give some indication of the magnitude of the AHA's current programs?

From its beginning 30 years ago as a small group of inadequately financed physicians, the American Heart Association today has grown to an organization of 55 affiliates and 1,314 local subdivisions, including 112 chapters. Its membership includes some 40,000 physicians, more than 88,000 other members from the health professions, and 2,000,000-plus volunteer fund-raisers.

The AHA is currently backing the work of some 1,400 researchers at a total outlay of more than \$21 million this year. These include support for the AHA "Established Investigator" program, universally regarded as a model of research funding, and the new "Clinician-Scientist" awards to help more clinically trained physicians enter research.

At the recent AHA Scientific Sessions, more than 1,200 presentations were made in several days of sessions attended by 15,000 health professionals, and by writers and broadcasters from all the major news media. The Interna-

(Please turn to page 273)



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Summary of 1979 House of Delegates

Highlighted in the following pages are the actions of the 1979 IMS House of Delegates. Significant actions were taken pertaining to the organization of the Society. Additional policy was set relating to health planning, physician's assistants, etc.

THE 1979 ANNUAL MEETING of the Iowa Medical Society House of Delegates was April 21 and 22 in Des Moines. Sessions of the House were chaired each day by L. D. Caraway, M.D., and R. T. Melgaard, M.D., speaker and vice speaker, respectively. Open hearings were conducted by the three reference committees on April 21. The Delegates' Banquet occurred April 21 and was chaired by Society President Russell S. Gerard, M.D. Special remarks were presented by Iowa Lieutenant Governor Terry Branstad and Robert B. Hunter, M.D., Sedro

Woolley, Washington, chairman, Board of Trustees, American Medical Association.

Winners of the 1979 Iowa Medical Society Merit Award were John M. Rhodes, Sr., M.D., Pocahontas, and Verne L. Schlaser, M.D., Des Moines. The 1979 Washington Freeman Peck Award was presented to the Iowa Medical Society Auxiliary on the occasion of its fiftieth anniversary. The John F. Sanford Award was presented to Mr. John W. Colloton, director, University Hospitals and Clinics and assistant to the President for Health Services, University of Iowa.

APRIL 21 SESSION

Registered for the April 21 session of the House were 132 delegates, 18 alternates and 9 ex-officio members. Minutes of the May 7, 1978 session of the House of Delegates were ap-

(Please turn to page 270)

Picture Highlights 1979 House of Delegates

These scenes are from the 1979 session of the IMS House of Delegates April 21 and 22: (1) John Kelley, M.D., Des Moines, IMS trustee, left, and Robert Hunter, M.D., Sedro Waalley, Wash., AMA board chairman. (2) 1979 IMS Merit Award winners Verne Schlaser, M.D., Des Moines, left, and John Rhodes, Sr., M.D., Pocahontas. (3) IMS President Russell Gerard, M.D., Waterloo, left, Mrs. Gerard, and Past-President Kenneth Lister, M.D., Ottumwa. (4) President-elect Paul Seebahn, M.D., Iowa City, left, and Lt. Governor Terry Branstad. (5) Accorded IMS Life Membership were standing left, Dwight Wirtz, M.D., Des Moines, Henry H. Wolf, M.D., Elgin, Emory Warner, M.D., Iowa City, Paul Leehey, M.D., Independence, and Cal Stark, M.D., Cedar Rapids; sitting left, Franklin C. Perkins, M.D., Hedrick, George Paschal, M.D., Webster City, Willard P. Marble, M.D., Marshalltown, and J. Stuart McQuistan, M.D., Cedar Rapids. (6) 1979 John Sanford winner John Callatan, Iowa City, and his wife. (7) Reference Committee on Articles & By-Laws, standing left, Charles Jons, M.D., Ames, and Martin Sakall, M.D., Iowa City; sitting left, Roger

Baulden, M.D., Lenox, Charles Hawkins, M.D., Clarion, and James White, M.D., Dubuque. (8) IMS Legislative Chairman Donald Young, M.D., Des Moines, addresses House. (9) Reference Committee on Legislation and Medical Service, standing left, Scott Helmers, M.D., Sibley, and Gardan Neligh, Jr., M.D., Council Bluffs; sitting left, Charles Jahnsan, M.D., Siaux City, Aaron Randolph, M.D., Anamasa, and Craig Ellyson, M.D., Waterloo. (10) Receiving the Washington Freeman Peck award on behalf of the IMS Auxiliary were Mrs. Nable Irving, Des Moines, and Mrs. Robert Weyrauch, Waterloo. (11) Reference Committee on Reports of Officers and Miscellaneous Business, from left, Robert Ferguson, M.D., Lake City, Lyle Fuller, M.D., Garner, Charles Dagle, M.D., Ft. Dodge, Norman Rinderknecht, M.D., Des Moines, and Wilmer Garrett, M.D., Masan City. (12) Blue Shield Board Chairman E. E. Linder, M.D., Ogden, reports to the House. (13) IMPAC Chairman Tam Kiernan, M.D., Newton, right, receives national membership award from Jack Lewis, M.D., Dayton, Ohio, AMPAC representative. (14) IMS Trustee James Bishop, M.D., Davenport, left, presents AMA-ERF check to Paul Seebahn, M.D., as College of Medicine Executive Associate Dean. (15) Foundation President Robert Westfall, M.D., Council Bluffs, reports to the House.

SUMMARY OF 1979 HOUSE OF DELEGATES

proved as published in the July 1978 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY. Reports contained in the 1979 HANDBOOK FOR THE HOUSE OF DELEGATES were approved as published.

A national third place award was presented to the Iowa Medical Political Action Committee for its level of sustaining memberships. The award was presented to IMPAC Chairman Thomas E. Kiernan, M.D., by Jack Lewis, M.D., Dayton, Ohio, on behalf of the American Political Action Committee.

The following reports were made to the 1979 House of Delegates:

Board of Trustees, by John H. Kelley, M.D., Chairman. (Associated with this report was an audio-visual presentation on 1979 IMS activity.)

Blue Shield, by E. E. Linder, M.D., chairman, Board of Directors.

Iowa Foundation for Medical Care, by Robert H. Westfall, M.D., IFMC president.

Scanlon Medical Foundation/Iowa Medical Society, by Hormoz Rassekh, M.D., member, Board of Directors.

Necrology, by John E. Tyrrell, M.D., chairman, Judicial Council.

Nominating Committee, by Lawrence O. Goodman, M.D., chairman.

Committee on Articles of Incorporation and By-Laws, by Kenneth J. Judiesch, M.D., chairman.

Legislative Committee, by Donald C. Young, M.D., chairman.

Iowa Medical Political Action Committee (IMPAC), by Thomas E. Kiernan, M.D., chairman.

Medico-Legal Committee, by Clarence H. Denner, Jr., M.D., chairman, with additional remarks by Darrell Chapman, IMS/Aetna account supervisor.

A check for \$15,004 was presented by James F. Bishop, M.D., IMS trustee, to the University of Iowa College of Medicine. The grant represents contributions to the AMA/ERF designated for the U. of I. Paul M. Seebom, M.D., executive associate dean, accepted the check.

Supplemental reports from the Committee on Delivery of Health Services, the Ad Hoc Committee on Genetic and Metabolic Screening and the Iowa Voluntary Cost Containment Committee were contained in the delegates' packets but were not read.

Society President Gerard presented highlights from his year in office. These remarks have been published in the June, 1979 issue of the JOURNAL OF THE IOWA MEDICAL SOCIETY.

Fifteen resolutions were formally introduced and referred to reference committees. Action taken on these resolutions is reported subsequently in this summary.

The following physicians were elected to Life Membership in the Iowa Medical Society:

Poul J. Leehey, M.D., Independence, Henry H. Wolf, M.D., Elgin, George A. Poschal, M.D., Webster City, Emory D. Worner, M.D., Iowa City, Franklyn C. Perkins, M.D., Hedrick, J. Stuart McQuiston, M.D., Cedar Rapids, Collistus H. Stark, M.D., Cedar Rapids, Willard P. Morble, M.D., Marshalltown, Carnelius Moris, M.D., Sonborn, and Dwight C. Wirtz, M.D., Des Moines.

The following physicians were elected to Associate Membership in the Iowa Medical Society:

Block Hawk: Fred Dick, M.D., Waterloo, Carl A. Hanson, M.D., Waterloo, Fred M. Morquis, M.D., Waterloo, and Lewis L. Zoger, M.D., Waterloo

Butler: Bruce V. Andersen, M.D., Greene

Homilton: Joseph L. Ptoczek, M.D., Webster City

Honcock-Winnebago: James O. Moermond, M.D., Buffalo Center

Linn: Richard G. Bousch, M.D., Cedar Rapids, and Cecilia M. Kurtz, M.D., Cedar Rapids

Morion: Dwight A. Moter, M.D., Knoxville

Marshall: Edson C. Knight, M.D., Marshalltown

Muscotine: Robert W. Astholter, M.D., Muscatine

Polk: Rudolph H. Duewoll, M.D., Clifford W. Losh, M.D., Louis J. Noun, M.D., Verne L. Schloser, M.D., and Elmer M. Smith, M.D., all of Des Moines

Pottawottomie-Mills: Rudolph Selo, M.D., Council Bluffs

Story: John D. Conner, M.D., Nevada, and Monson G. Fee, M.D., Ames

Webster: Walter E. Gower, M.D., Fort Dodge

Woodbury: Poul W. Osincup, M.D., Sioux City

Wright: Samuel P. Leinboch, M.D., Belmond

The speaker presented information on the reference committee hearings, the balloting procedures and the concluding session of the House.

APRIL 22 SESSION

Registered for the April 22 session of the House were 122 delegates, 18 alternates and 9 ex-officio members. The minutes of the April 21 session of the House were read and approved.

Mrs. Florence Irving, who completed her term as president of the Iowa Medical Society Auxiliary the preceding day, reported on the work of this organization.

(Please turn to page 271)

SUMMARY OF 1979 HOUSE OF DELEGATES

The following physicians were announced as having been elected or re-elected to the positions noted:

President-elect	William R. Bliss, M.D., Ames
Vice-President	Albert M. Dalan, M.D., Waterloo
Speaker of the House	Lynn D. Caraway, M.D., Amana
Vice Speaker	William C. Rasenfeld, M.D., Mason City
Trustee (3-year term)	Maurice E. Kraushaar, M.D., Ft. Dodge
AMA Delegate (2-year term)	Jahn R. Anderson, M.D., Boone
AMA Alternate Delegate (2-year term)	Emmet B. Mathiasen, M.D., Council Bluffs
Liaison Delegates	Cecil W. Seibert, M.D., Waterloo Jackson D. Ver Steeg, M.D., Des Moines Clarkson L. Kelly, M.D., Charles City (1) Daniel M. Youngblade, M.D., Sioux City (4) Albert M. Dalan, M.D., Waterloo (6) (Robert T. Guthrie, M.D., Waterloo, was named councilor until the next meeting of the House following election of Dr. Dalan as vice-president.) Arthur L. Sciartina, M.D., Council Bluffs (11)
Councilors	

Highlights and actions of the Reference Committee reports are summarized as follows:

REFERENCE COMMITTEE ON ARTICLES OF INCORPORATION AND BY-LAWS — Charles Hawkins, Chairman, Rager Boulden, Charles Jons, Martin Sakall, and J. W. White

A major updating of the IMS Articles and By-Laws was considered by the Reference Committee and the following recommendations were adopted by the House:

House Action: Amended Article VIII of the Restated Articles to read: "After the adjournment of the annual House of Delegates meeting in 1980, the Board of Trustees shall consist of three trustees and the president, president-elect, vice-president and immediate past-president. It shall have charge of the property, employees and financial affairs of the Society and shall perform such duties as are prescribed by law governing directors of corporations or as may be prescribed in the By-Laws. The Board of Trustees shall elect one of the trustees as chairman and one of the trustees as secretary-treasurer; it shall exercise the executive powers of the Society."

House Action: Adopted the Restated Articles of Incorporation as amended.

House Action: Voluntarily adopted the provisions of the Iowa Nonprofit Corporation Act.

House Action: Approved the address of its initial registered office as 1001 Grand Avenue, West Des Moines, County of Polk, and noted its registered agent as Eldon E. Huston.

House Action: Confirmed the present 12 councilor districts.

House Action: Approved two councilor districts per congressional district (except for Polk County in the fourth congressional district). On adjournment of the 1980 House, Polk will divide into two councilor districts, split equally by alphabet.

House Action: Designated the Executive Council to develop redistricting matters and councilor election activity for consideration by the 1980 House of Delegates.

House Action: Adopted the proposed IMS By-Laws.

House Action: Authorized and directed the appropriate officers to make necessary editorial changes in the Restated Articles of Incorporation and By-Laws and do all things necessary to institute this official language and to adopt voluntarily the provisions of the Iowa Non-Profit Corporation Act.

House Action: Authorized the Board of Trustees to formally adopt the By-Laws as approved by the House, as soon as convenient after the Restated Articles of Incorporation have been effectuated.

REFERENCE COMMITTEE ON LEGISLATION AND MEDICAL SERVICE — Gardan Neligh, Jr., Chairman, Craig Ellysan, Scott Helmers, Charles Jahnsan and Aaron Randolph

House Action: Supported appropriate legislation to be developed by the Committee on Legislation to require packaging and labeling of drugs by dispensing physicians under jurisdiction of the Board of Medical Examiners.

House Action: Reaffirmed opposition to legislation granting use of diagnostic and/or therapeutic drugs by reform of the Optometric Practice Act.

House Action: Authorized IMS study to identify any impending shortage of primary care specialists and, if identified, okayed support for additional state funding to assist efforts

SUMMARY OF 1979 HOUSE OF DELEGATES

similar to the Iowa Family Practice Residency Program.

House Action: Rejected a proposal to initiate legislation to allow third-party payment for organized patient education programs.

House Action: Rejected a resolution requesting, among other things, that Blue Shield discontinue its participating/non-participating philosophy for physicians, and that assignment of allowances be made to all physicians when specified by the patient.

House Action: Urged elimination of non-essential services in nursing homes to restrain cost increases and allow Iowans to be independent and responsible for living accommodations as long as possible; additionally, this matter was requested to be transmitted to the AMA for pursuit at the federal level.

House Action: Asked Blue Shield to recognize a single screen for all specialties as an option along with other options in claims adjudication.

REFERENCE COMMITTEE ON REPORTS OF OFFICERS AND MISCELLANEOUS BUSINESS — Charles Dagle, Chairman, Robert Ferguson, Lyle Fuller, Wilmer Garrett, and Norman Rinderknecht.

House Action: Retained IMS dues for 1980 at the present level of \$275.

House Action: Commended the Board of Trustees for good management of the IMS.

House Action: Approved the concept of newborn screening for metabolic disorders to be accomplished through (1) use of existing independent or hospital laboratories only, or (2) in conjunction with a central or regional laboratory which would test for metabolic disorders for reason of inaccessibility to existing independent or hospital laboratories or referral from existing independent or hospital laboratories; approved a central or regional lab, if needed, to coordinate a program of data retrieval and quality control.

House Action: Declined a resolution endorsing an article discussing food and water restriction in the wrestler and affirming guidelines for

proposed use by the Iowa High School Athletic Association.

House Action: Acknowledged performance of IMS/Aetna liability insurance program and cited 1979 improvements with the request that information continue to be promulgated; also cited good work of Mr. Darrel Chapman as account supervisor.

House Action: Approved IMS establishment of an ongoing task force of statewide, coordinated physicians to influence and improve the present health planning process; endorsed continued communication with those physicians involved in health planning, and supported provision of expert counsel and resource information to health planning bodies on important health planning issues.

House Action: Reaffirmed policy of opposition to legislation granting physician's assistants statutory authority to prescribe medications.

House Action: Agreed prescription writing should be limited to licensed doctors of medicine, osteopathy, osteopathic medicine and surgery, dentistry, podiatry and veterinary medicine.

House Action: Defeated a resolution endorsing a recommendation attributed to the State PA Advisory Committee having to do with prescribing and dispensing by PA's.

House Action: Amended a 1978 IMS House action referring to physician's assistants by deleting references to family nurse practitioners, then reaffirmed the 1978 action as expressing current IMS policy, acknowledging that in some areas health care needs of a population may be met only through a properly supervised PA-staffed satellite clinic.

House Action: Declared IMS members be reminded continually that any abuses by PA's or their supervising physicians should be reported to the Board of Medical Examiners.

House Action: Supported evaluation and determination of the need to curtail or terminate the University of Iowa PA training program as the number of primary care residencies increases and the need for primary care physicians is satisfied.

House Action: Urged that the public be reminded the primary interest of physicians is to assure the highest quality of medical care.

House Action: Asked that the Delivery of Health Services Committee continue to meet with representatives of the Board of Medical Examiners, the Iowa Physicians Assistants So-

SUMMARY OF 1979 HOUSE OF DELEGATES

ciety and others on issues relating to the use of PA's in Iowa.

House Action: Affirmed the rigorous educational qualifications now required for licensure into medical practice, indicating they are necessary for protection of the public.

House Action: Opposed shortcuts to medical practice which will evade or nullify current high standards and circumvent educational license requirements.

House Action: Opposed efforts of non-physicians to invade medical practice, including the diagnosis and treatment of disease, the prescribing of medication, and the performance of surgical procedures without meeting the same educational standards as physicians.

The House approved a motion that the actions of the Board of Trustees of the Iowa Medical Society from the date of the last annual meeting to the present be ratified and affirmed. The House also acknowledged the distinguished and effective service of Russell S. Gerard, M.D., as president of the Iowa Medical Society. The 1980 session of the IMS House of Delegates was announced for May 3 and 4 at the Hilton Inn in Des Moines.

QUESTION BOX

(Continued from page 267)

tional Stroke Conference, and the annual Epidemiology Conference, while smaller in scale, are of equal importance in both professional and public education.

Other AHA programs in continuing education, public health advocacy, CPR, blood pressure screening and publications for both professional and lay readers, contribute measurably both to health and knowledge.

Would you encourage other physicians to become involved in the activities of voluntary health organizations such as the AHA?

I cannot urge it too strongly. Here is where physicians can provide useful leadership far out of proportion to their numbers.

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before treatment. If an allergic reaction occurs, discontinue the drug and treat with the usual agents (e.g., epinephrine or other pressor amines, antihistamines, or corticosteroids).

Precautions: Use with caution in individuals with histories of significant allergies and/or asthma. Do not rely on oral administration in patients with severe illness, nausea, vomiting, gastric dilatation, cardiospasm, or intestinal hypermotility. Occasional patients will not absorb therapeutic amounts given orally. In streptococcal infections, treat until the organism is eliminated (minimum of ten days). With prolonged use, nonsusceptible organisms, including fungi, may overgrow; treat superinfection appropriately.

Adverse Reactions: Hypersensitivity, including fatal anaphylaxis. Nausea, vomiting, epigastric distress, diarrhea, and black, hairy tongue. Skin eruptions, urticaria, reactions resembling serum sickness (including chills, edema, arthralgia, prostration), laryngeal edema, fever, and eosinophilia. Infrequent hemolytic anemia, leukopenia, thrombocytopenia, neuropathy, and nephropathy, usually with high doses of parenteral penicillin.

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SCIENTIFIC ARTICLES

Thyroid Crisis

S. T. SHETTY, M.D.

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This case report describes a rare and if not treated fatal syndrome. The author seeks to increase physician awareness of "thyrotoxic crisis," in the hope others will be helped to make an early diagnosis and extend appropriate treatment.

THYROID CRISIS or storm is a life-threatening augmentation of the manifestations of hyperthyroidism. In the past, it was common during or immediately after thyroid surgery. Since the advent of anti-thyroid drugs and beta-adrenergic blockers, the thyroid crisis during or after surgery, the so-called "surgical crisis," is almost unknown. Currently, patients with hyperthyroidism have surgery and often radioactive iodine treatment in a euthyroid state. Thyroid crisis is rare but still seen in patients with previously undiagnosed hyperthyroidism. It is usually precipitated by infec-

tions, diabetic acidosis, trauma or non-thyroidal surgery. It is of utmost importance to be aware of this syndrome because, if not diagnosed early and treated promptly, it is almost always fatal. Several review articles on thyroid crisis have appeared recently but the diagnosis and treatment remain difficult and the mortality rate is still high.

CASE REPORT

A 59-year-old white female was admitted to North Iowa Medical Center in February, 1976, from another hospital. Two weeks prior to admission, she had a flu-like syndrome with diarrhea. Two days before admission, she was admitted to another hospital with chest pain, abdominal pain, shortness of breath and fever. Her temperature was 103.8 degrees F. The chest X-ray in that hospital showed pneumonia and she was started on antibiotics. The patient became unconscious, and her blood sugar was reported to be 40 mgm percent. At this stage, she was transferred to North Iowa Medical Center in Mason City.

Significant past history included goiter surgery in 1951. She was not taking thyroid medication. She had heart disease and was

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taking digitalis. At the time of admission, she was comatose and had a fever of 101 degrees F. Her pulse rate was 120 per minute and irregular. Cardiac enlargement was present clinically. A thyroidectomy scar was visible in the neck and the left lobe of the thyroid was diffusely enlarged. No localizing neurological deficits were present. The chest X-ray showed pulmonary congestion, cardiac enlargement and possible pneumonia. The electrocardiogram showed atrial fibrillation with multiple ventricular extra systoles. The white blood cell count was 8200 with a normal differential count. The blood sugar was 63 mgm percent and electrolytes were normal. The spinal fluid examination was normal. The serum thyroxin (T₄) was 17 mcg per 100 ml (normal 4-11 mcg per 100 ml). Repeat examination showed T₄ to be 18.6 mg per 100 ml with free thyroxin being 7.8 mcg per 100 ml (normal 0.6 to 2.6). Tri-iodothyronine (T₃) was 162 nanograms per 100 ml (normal 120-312 nanograms per 100 ml).

The patient was started on propylthiouracil, 150 mgm every six hours and saturated solution of potassium iodide, 5 drops every six hours. She was treated with digitalis and diuretics for congestive heart failure and also hydrocortisone, 100 mgm intravenously every six hours. Antibiotics were used because of suspected pneumonia. Initially, the patient was given propranolol (Inderal) 20 mgm every six hours, but later it was stopped because of congestive heart failure. Intravenous fluids and electrolytes were given as needed. With this regimen, the patient improved remarkably and was alert within 48 hours after starting treatment. The patient was maintained on propylthiouracil 100 mgm every six hours. About five weeks later when the patient was euthyroid, she was treated with radioactive iodine for definitive treatment of thyrotoxicosis. She required a second dose later and has continued euthyroid.

INCIDENCE

The incidence of thyroid crisis is around 2 percent of all hyperthyroid patients admitted to a general hospital. The true incidence is probably not known because the criteria for diagnosis differ according to different physicians. As in hyperthyroidism, the incidence

is about nine times more common in women compared to men.

PATHOGENESIS

The pathogenesis of thyroid crisis is not known but various explanations have been offered. Thyroid storm has been called decompensated thyrotoxicosis, suggesting an exhaustion of the body's tolerance to the excessive hormone. The manifestation of the crisis is said to be the result of an acute adrenergic outburst in patients sensitized by excessive thyroid hormone to the effects of epinephrine, norepinephrine and other adrenergic stimuli. The amount of circulating thyroid hormone in thyroid crisis is the same as the usual cases of thyrotoxicosis without crisis. This suggests something besides the quantity of hormone is responsible.

The overall catecholamine metabolism is unaltered in thyrotoxicosis. Two distinct adenylyl cyclase systems are postulated in the heart, one responsive to epinephrine and the other to thyroid hormones. The effects of epinephrine and thyroid hormones are additive. Beta-adrenergic blockade prevents stimulation of adenylyl cyclase by norepinephrine but not by thyroid hormones.

Adrenal insufficiency (hypocortisolism), whether due to reduced biological half-life of cortisol or due to the precipitating causes of thyroid crisis, seems to be present and reversed by steroid therapy.

CLINICAL FEATURES

The clinical features of thyrotoxic crisis are dominated by manifestations of hypermetabolism mainly involving cardiovascular, nervous and gastrointestinal systems. Fever is universally present and may be quite high. Tachycardia and other cardiac arrhythmias, especially atrial fibrillation, are quite common. Congestive heart failure is not uncommon, especially in the elderly. The blood pressure is usually well maintained, but shock will manifest in the advanced stage of crisis. Tremulousness and restlessness are early central nervous system symptoms, and may lead to confusion, apathy, agitation, frank psychosis

and coma. Gastrointestinal symptoms may include diarrhea, nausea, vomiting, abdominal pain and jaundice. The precipitating causes, infection or trauma, can produce all the above manifestations and may mimic thyroid crisis.

The above clinical picture in a patient with a history of thyrotoxicosis, goiter or exophthalmos should be sufficient to make the diagnosis of thyroid crisis. The outcome of thyrotoxic crisis greatly depends on early recognition and prompt treatment and a high degree of suspicion should be maintained. The diagnosis of thyroid crisis must be based on the clinical picture and usually one does not have the luxury of waiting for laboratory confirmation. The treatment should be immediately started once the diagnosis is made or suspected, after drawing blood samples for hormone measurements.

TREATMENT

There are no established criteria by which severe thyrotoxicosis complicated by some other disease can be distinguished from the "thyroid crisis" induced by that disease. In any case, the treatment of both conditions is the same. In the treatment of thyroid crisis, four objectives must be kept in mind. First of all, one has to (1) diagnose and treat the underlying illness or precipitating cause or causes; (2) provide general supportive measures; (3) reduce the secretion and production of thyroid hormones, and (4) diminish the metabolic effects of thyroid hormones.

Antithyroid drugs, such as propylthiouracil, 600-1000 mgm daily in divided doses or methimazole 60 to 100 mgm given orally or by nasogastric tube, can prevent organic binding of iodide in thyroid within the hour. These drugs prevent the synthesis of thyroid hormones.

Iodide should be given in the form of Lugol's solution, 5 drops every 4 hours or sodium iodide, 1 gram intravenously every 8 hours. Iodides retard the release of thyroid hormones from the thyroid gland. Iodine should be given at least 1 hour after giving antithyroidal drugs, so the administered iodide will not be utilized for thyroid hormone synthesis.

The metabolic effects of thyroid hormones may be ameliorated by the adrenergic blocking drugs. Propranolol hydrochloride (Inderal) is

the drug of choice unless definite contraindication, such as severe heart failure or bronchial asthma exists. Inderal can be given 20-40 mgm 4 times a day orally or 1-2 mgm intravenously, if needed. Cardiac arrhythmias are well controlled by propranolol. Other adrenergic blocking drugs used include reserpine 2.5 mgm intramuscularly every 4 to 6 hours. Reserpine is slow in its action and may cause central nervous system depression. Guanethidine sulfate (Ismelin) 25-150 mgm orally may be given. It takes about 24 hours for its action and maximal action takes several days.

The general supportive care includes the replacement of fluids, glucose, electrolytes and vitamin B complex. Sponge baths and cooling blankets should be used to reduce fever. Diuretics, digitalis and oxygen should be used if patient is in congestive heart failure. Although documented adrenal insufficiency is rare in thyroid crisis, 200-500 mgm hydrocortisone daily parenterally is the course of treatment recommended by most workers.

After the patient improves, iodine should be withdrawn in preparation for the administration of radioactive iodine, which is the most common treatment. Antithyroid drugs are continued until patient is euthyroid.

The use of plasmapheresis and peritoneal dialysis in treatment of thyrotoxic crisis has been reported.

SUMMARY

In summary, thyrotoxic crisis is a clinical diagnosis and once suspected early treatment is essential to reduce the high mortality rate. Any patient with a goiter or hyperthyroidism under stress may develop this crisis. Early diagnosis, recognition and treatment of precipitating causes and specific treatment with antithyroidal drugs, iodine, adrenergic blocking agents and hydrocortisone, can reduce the mortality significantly.

ACKNOWLEDGEMENT

The author thanks George H. West, Jr., M.D., endocrinologist, Park Clinic, Mason City, for his advice in preparing this article.

Congenital Dislocation of the Hip

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The key to effective treatment of congenitally dislocated hips is early detection. Primary care physicians have a responsibility here. The easy diagnostic maneuvers described will help those physicians who care for infants.

SINCE 1950 EARLY DIAGNOSIS of CDH (Congenital Dislocation of the Hip) has increased in frequency after a lecture tour through Iowa by members of the Orthopaedic Department at the University of Iowa. Even so some cases are missed. It is the purpose of this paper (1) to reiterate the need for early diagnosis and (2) to review the tests which must be done for all babies (in nurseries and well baby clinics) to reduce or eliminate the crippling hip condition which results from late treatment.

Family practitioners, pediatricians, and obstetricians should be able to diagnose CDH soon after birth, preferably in the nursery. Repeated studies have shown early treatment to be the "only means of obtaining good results with consistent regularity."² Hippocrates first described congenital dislocated hips clinically. Palleta of Milan dissected and reported a bilateral case in the 18th century. During this time

period, Dupuytren predicted all methods of treatment would fail. In 1894 Pacci popularized closed reduction, while in 1927 Putti emphasized early detection, claiming 94% perfect reductions in children under one year of age. The necessity of early diagnosis was stressed again by Ortlani in 1948 when he described his famous clinical sign.

Congenital hip dislocation is not an uncommon problem. From January, 1970 to December, 1976, there were 16,294 live births at the University of Iowa Hospitals. Twenty of these babies had congenital hip dislocation diagnosed by a positive Ortlani's sign. The incidence therefore was 1.2 per thousand live births.¹³ This compares favorably with the incidence reported in other cities,^{1, 9, 10} and it is slightly lower than the incidence observed here in the 1950's and 1960's.

TWO TYPES OF CDH

CDH can be divided into two types: 1) teratologic dislocations which have been present since early uterine life and may include association with generalized disease processes like arthrogryposis; and 2) typical dislocations which develop late in the fetus. The first group is often resistant to treatment, but fortunately is rare.

Early reduction of the second group is important since the potential for proper acetabular development decreases with increasing age. Acetabular and femoral head development is dependent upon maintenance of a concentric reduction.

A 20-30% familial incidence of CDH has

Dr. Ponseti is a professor; Dr. Weinstein is an assistant professor; and Dr. Wheeler is a resident in the Department of Orthopaedic Surgery at University of Iowa College of Medicine.

been reported. Careful examination of the offspring and relatives of patients with CDH is required. Other implicated factors are primiparous mothers, oligohydramnios, sudden hip extension at birth, and infant carrying positions. Barlow² observed the association of breech deliveries with CDH is more common in females and is possibly associated with ligamentous laxity. Additional conditions often associated with CDH are torticollis, metatarsus adductus, and other foot deformities.

Physical findings of CDH include asymmetry of thigh and gluteal folds, thigh shortening and hip "clicks." Ortlani's test is performed with the infant supine and the hips and knees flexed to 90 degrees. The middle fingers are placed over the greater trochanters while the thumbs are placed on the lesser trochanters. The hips are then slowly abducted with pressure over the greater trochanters. A palpable "click or thud" sensation indicates reduction of the dislocated or subluxed hips. Also with the legs in mid abduction, posterior pressure can be applied to the lesser trochanters with the thumbs and a "click or thud" then indicates a dislocation or unstable hip. It is essential this test be performed with the baby relaxed.

Untreated CDH may delay walking by two or three months. In children starting to walk unilateral involvement causes an asymmetric limp with a positive Trendelenburg test. The buttock is flat and a pelvic tilt with functional scoliosis may develop. In bilateral cases, a waddling gait with hyperlordosis is evident. Any gait abnormality in a child should not be dismissed without a careful clinical and roentgenographic examination.

RADIOGRAPHIC MEASUREMENTS

A variety of radiographic measurements and techniques have been described (Figure 1). In general, there appears to be a lateral displacement and/or delayed appearance of the ossific nucleus of the femoral head (normally present at 5 through 7 months). Shenton's line is disrupted (Figure 1). The intersection of Hilgenreiner's and Perkins line form quadrants and the ossific nucleus should lie in the inferior medial quadrant (Figure 1). The acetabular

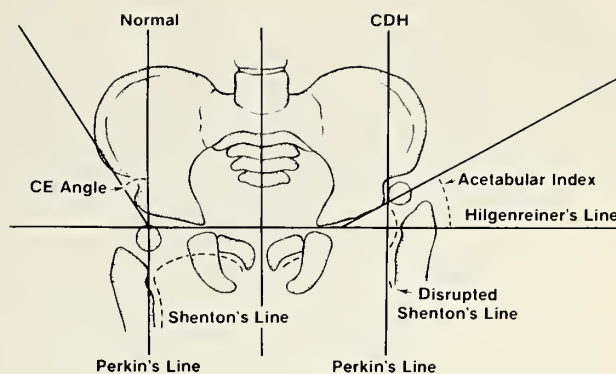


Figure 1

index should be less than 30 degrees in the newborn and less than 24 degrees in an older child, while a CE (center edge) angle of less than 25 should be considered abnormal. The measurements of acetabular formation do not change after puberty and little after age 5.

Pathologically, many factors may hinder reduction of a dislocated hip. With persistent dislocations there will be hypertrophy of the capsule with adherence to the wall of the ilium. The anterior medial hip capsule may become quite taut as well as the tendon of the iliopsoas. Intracapsularly, the ligamentum teres may be thickened and impede reduction. The labrum (fibrocartilaginous rim of the acetabulum) may be inverted and block reduction on rare occasions. In a teratologic dislocation there is often great discrepancy between the size of the femoral head and the acetabulum. The femoral head is often large and deformed while the acetabulum is shallow, and there may be a fairly well formed secondary acetabulum.

Barlow² found 80% to 90% of "unstable" hips will recover spontaneously, but it is impossible to distinguish at birth which hips will become normal from those that will progress to subluxation and dislocation. Therefore, where there is clinical suspicion of congenitally dislocated hips, treatment should be instituted immediately.

From birth to age 2 months most hips can be treated for 6 through 8 weeks by an abduction device such as a Frejka pillow, Pavlik harness, or Von Rosen splint. An abduction brace is then worn full time for an additional 6 to 8 weeks and at sleeping times for an additional 3 to 4 months.

Of the 20 patients born at University Hospitals between January, 1970 to December, 1976, with a CDH diagnosis, 18 were treated successfully with a pillow splint. Of the two that remained dislocated one mother confessed she did not use the pillow. This suggests the number of CDH patients that will need further treatment, such as open reductions, may be only 5%.

After age 2 months the treatment regimen is more complex. The same principle applies to replacement of the femoral head and maintenance of the reduction for several months. Clinical reductions may be accomplished up to the age of 20 months but often necessitate skin traction and arthrograms followed by prolonged casting and bracing. Open reduction is usually necessary after age 18 through 20 months as soft tissues have become rigid and the acetabulum and femoral head may be deformed.

Almost invariably pelvic osteotomies and femoral derotation osteotomies are necessary, if the congenitally dislocated hip is not diagnosed until 4 to 7 years of age. After 6 years the major decision is whether to treat at all. In most bilateral dislocations treatment is not indicated. For subluxing hips a pelvic osteotomy may be needed. Arthroplasty in cases of gross acetabular dysplasia is used only when no other method is effective.

As the age at time of diagnosis increases, the severity and uncertainty of treatment becomes evident.

RESULTS AND COMPLICATIONS

A long time follow-up at University Hospitals, comparing age at diagnosis to the Iowa Hip Rating³ as an adult, confirms the value of early diagnosis and treatment.⁴ Those hips reduced during the first year of life averaged 97/100 points. Those reduced during the second year of life averaged 92/100. Those reduced after the second year of life averaged 70.9/100.

Smith,¹¹ in a 31 year follow-up, demonstrated results correlated with age at initial treatment. Ponseti stated subluxed hips appear

to be more painful than frank dislocations and late treatment may convert dislocated hips into painful subluxed ones.

Complications of treatment tend to be more frequent in older patients.

Perhaps the most feared and common complication is aseptic necrosis which has a frequency of zero through 68% in different series. The capital femoral epiphysis usually appears at age 6 months. The blood supply is initially through the medial and lateral circumflex vessels as well as the obturator artery. At approximately 1 year of age, Ogden⁵ demonstrated that this system changes to a predominately medial femoral circumflex supply. In addition, after 1 year of age, end arteries no longer cross the epiphyseal plate. This one vessel system can then be compromised by marked abduction at the labrum and the intertrochanteric groove or at the iliopsoas and adductor longus tendons with abduction, extension, and internal rotation. Aseptic necrosis of the normal hip may occur during treatment of the opposite hip, possibly due to wide abduction positioning in the cast or splint.

SUMMARY

Many authors have advocated prereluction traction to decrease the incidence of aseptic necrosis. The Iowa series⁴ demonstrated prereluction traction did not effect the development of necrosis.

If closed reduction cannot be obtained or maintained, open reductions are indicated. In children under 2 years of age a medial approach is used.¹³

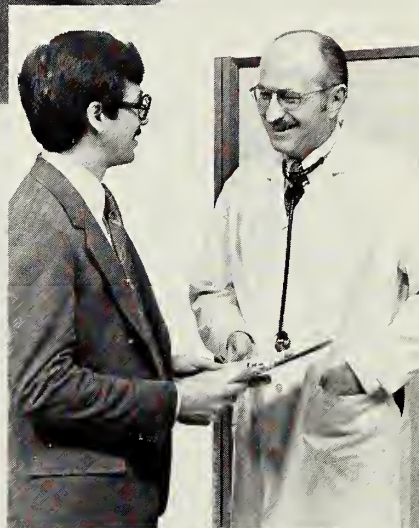
The key to effective treatment of congenitally dislocated hips is early detection. This responsibility lies with the primary care physicians. Tragic late results can be avoided by the relatively easy diagnostic maneuvers described. The awareness of congenitally dislocated hips and its prompt referral for early therapy is essential.

REFERENCES

The references noted in this paper are available on request either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.



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MEDICAL MISCELLANY

SCHEDULE A LIABILITY MEETING . . .

County medical societies looking to fall/winter program possibilities are invited to consider a presentation by Dave Heath, new account supervisor for the IMS/Aetna Liability Insurance Program. These educational sessions will provide important information on professional liability conditions. The programs are beneficial to all physicians regardless of their liability insurance carrier. Contact IMS headquarters for assistance in arranging a meeting; IN-WATS telephone is 1/800-422-3070.

DENTAL COVERAGE GROWS . . .

Growth of dental insurance in Iowa has been reported as good. Membership in the Delta Dental Plan of Iowa has more than doubled to 85,000 Iowans since 1977. The program is sold and administered by Blue Cross and is available only to groups.

MARIJUANA BILL SIGNED . . .

Iowa Governor Ray signed into law June 1 legislation allowing limited use of marijuana for medical purposes. The Board of Pharmacy Examiners must appoint a group of physicians to advise on the type of program to be undertaken. Technically, the program must be classified as a research project if it is to meet federal stipulations.

HYPERTENSION COMMITTEE . . .

Names of the following physicians have been submitted to the State Health Commissioner for appointment to a State Hypertension Control Advisory Committee: Chad Williams, M.D., Des Moines; George Spellman, M.D., Sioux City; Edwin Motto, M.D., Davenport, and Forrest Dean, M.D., Muscatine.

PRIORITIES . . .

The top IMS concern (and/or priority), at least in the minds of the Society's administrative staff, is encroachment into medical practice. Categorized behind encroachment in a recent staff planning session were (2) legislation and political action, (3) third party programs (public and private), (4) cost of medical care, and (5) health planning.

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WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. *Drug Dependence.* Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. *Use in Pregnancy:* Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. *Use in Children:* Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSEAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

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Anticipate New List Of Impairments For Disability Evaluation

H. E. WICHERN, M.D., and

F. PRICE FARSON

Des Moines

THE SOCIAL SECURITY DISABILITY PROGRAM (SSDP) undergoes continuous change. In its early years the program was restricted and the listings of impairments for evaluating disability were comparatively brief. It was believed then that to list all of the potentially disabling impairments would make the listings voluminous and impractical for easy reference. Consequently, only the more common disabling impairments were listed.

As time has passed, these original listings have undergone deletion, addition and modification. Both program experience and advances in medical knowledge have uncovered the more discreet relationships between impairment and the inability to work. This has caused useful expansion of the listings.

In addition, the advent of Title XVI, Supplemental Security Income Program, has brought about a further expansion in the listing of impairments. We are able to report that new and revised listings have been published and are in the process of being implemented. Essentially, these newly revised listings reflect those medical conditions (physical and/or mental) which are the most commonly disabling and which generally preclude ability to work.

Dr. Wichern is chief medical consultant and Mr. Farson is assistant director of the Disability Determination Services for the State of Iowa.

New and revised Listings of Impairments for Disability Evaluation under Social Security are being put to use by the Iowa Disability Determination Services Division. These new listings will have an effect on medical reporting requirements. The listings will be made available to Iowa physicians in the near future.

There is no universally accepted definition of the term "disability." The hundreds of federal, state, commercial and private programs have individual specific and different definitions of "disability." In each of these programs, individuals cannot qualify unless they meet the prescribed criteria of "disability" established for the specific program which is applicable.

The majority of other "disability" programs stress the degree of illness or injury as the primary qualifying criterion. However, the Social Security Disability Insurance Program has established *The Inability to Work (engage in substantial gainful activity)* as the primary criterion, with the augmenting provision that this inability to "work" be due to a physical or mental impairment.

Impairment is an essential criterion of the SSDP. However, as opposed to the orientation of other insurance programs which emphasize only the degree of impairment, the SSDP is a work-oriented program wherein impairment is significant only to the degree that it prevents work.

MEDICAL FACTORS SOLE BASIS

Additionally, the listings level of severity does not establish "disability." It only estab-

lishes the degree of impairment. Medical factors can be the sole basis for a determination of disability only after eligibility requirements are met and investigation discloses documented absence from work. The evidentiary requirements of the program must be fulfilled to achieve participation.

The new revised listings of impairments (Physicians' Handbook) is now being printed. Copies will be provided to the Iowa medical community when they become available. We hope the new document will help physicians better understand the SSDP and be useful in providing our agency with desired and necessary objective medical evidence needed for a sound determination.

GETTING THEM IMMUNIZED

In Iowa each year approximately 8,000 children appear for kindergarten without having completed all the recommended immunizations. This figure has been ascertained by the State Department of Health.

Under the two-year old Iowa immunization law children must receive this protection as a condition of entry into school. However, as noted, many pass through the pre-school years remaining susceptible to one or more of the immunizable diseases.

Immunizing these pre-schoolers is an obvious and desirable goal. Effort in this direction has been endorsed by the Iowa Medical Society Executive Council and the IMS Committee on Maternal and Child Health. It is among the objectives set forth in the Annual Implementation Plan of the Iowa Health Systems Agency.

Start-up and continuation of an immunization schedule requires the dual attention of the parent and the physician. Various effective patient recall systems are in existence. They are encouraged among physicians providing primary care to children. Unfortunately, some parents need to be reminded regularly of the importance of keeping the immunizations of their children up to date. Such reminders may

The Iowa Disability Determination Services wishes to thank Iowa physicians and hospitals for their cooperation. Without this assistance the IDDS would be unable to properly develop and adjudicate the thousands of applications received each year for disability benefits under the Social Security Disability and Supplemental Security Income Programs.

Information on the Disability Determination Services or the programs it administers will be provided to Iowa physicians on request. The address is 507 Tenth Street, Fourth Floor, Des Moines, Iowa 50309; the telephone number in Des Moines is 281-4474; the toll-free WATS number is 1/800-362-2900.

be given before or during an appointment, or in some alternate way if an appointment is missed.

A simple tickler file can be used to identify children due for immunizations. When the child becomes a patient an immunization record is established. It becomes an item for routine review. Appointments can be scheduled around times for immunizations. It is possible from patient records to establish a 3 x 5 tickler file system with cards arranged by month to indicate when Johnny or Mary need their next immunizations. Once in the tickler file the child's name (or the parent's name) or card can be rotated to the month of the next appointment. If an appointment is missed a note or call can be made to remind of the important immunization.

The tickler file system can be structured variously to assure appropriate office visits are scheduled. Patient immunization audit cards are available from the Iowa State Department of Health to assist physicians. These can be placed in a 3 x 5 file separated by month dividers. Contact to remind parents of immunizations needs can be done when time of the staff permits. Such contact may be restricted to patients who have missed an appointment.

Several Iowa physicians are known to use the tickler file effectively to keep children on an immunization schedule. Where this has been done routinely a higher level of immunization has been noted by the schools in the area.



Editorials

M. E. ALBERTS, M.D., Scientific Editor

PUBLICATION LAG TIME

The passage of time from receipt and acceptance of a manuscript and its actual publication in the JOURNAL is much longer than we desire. Ours is not a unique situation. Some journals hold manuscripts for up to two years before informing the author of their rejection, or it may be 18 to 24 months before publication. Medical journals share this dilemma with various scholarly journals in other disciplines. An article on the front page of the May 25 issue of the WALL STREET JOURNAL addresses itself to a problem known as "publish or perish."

I would be distressed to know a delay in publication or the rejection of a manuscript submitted to our JOURNAL was instrumental in causing a writer to perish. We receive many excellent manuscripts. Often the rejection or delay in publication is very distressing to us. Yet, so it must be in many instances. Our JOURNAL is widely read. We have attained recognition among our peers. Many are eager to have their writings published. For this we are grateful, and fortunately Iowa physicians, for the most part, write well, and submit timely articles. Yet, often we may receive several papers on a similar subject or in the same discipline of medicine. It becomes necessary to select and reject. An article is not judged by its length or by the extent of the references cited. We feel our JOURNAL must appeal to as many busy Iowa physicians as possible, practitioners in the smaller towns and cities as well as those more academically oriented in the larger medi-

cal centers. We want to appeal to as many readers as possible.

Some ask if we have priorities. In several ways we do exercise a kind of priority system. Concise, succinct, timely, informative articles will always have a priority of sorts. Is the report a knowledgeable observation by a practitioner, or the review of a subject originally presented as a paper at a medical meeting? Is the article a current review of a reappearing medical problem? Is the subject matter presented in an understandable fashion, or is it a long recital of words too technical or too confined in area of interest? Is there too much repetition of textbook word-for-word discussion? Does the author come to conclusions that are valid as well as valuable to the reader? Last, but certainly not an ultimate cause for absolute rejection, is the manner of presentation. A relatively few articles submitted would not pass a high school English course. If the message is good and has strong enough appeal we edit (sometimes completely rewrite in an acceptable fashion) for the author. We realize many physicians have not had the experience of writing scientific articles. (No, we do not contract to do ghost writing.) Another priority, which seems only fair, is that we must display some preference to articles submitted by members of the Iowa Medical Society. Our JOURNAL is supported by the Society, therefore, support must be mutual. Timely, exceptional articles will be accepted from other physicians from time to time, but such is the exception rather than the rule.

I hope this brief comment will help you

(Continued on page 286)

EDITORIALS

(Continued from page 285)

understand the reasons for any delay in publication. It would be nice if we had unlimited funds to publish a journal thrice our present size. We are restricted by the number of pages available, and consequently this limits the number of articles we can publish in each issue.

HOT LINE MEDICAL INFORMATION

You have all received at sometime an inquiry from an insurance company which offered the option of dictating a medical report on a toll-free long distance line instead of filling out a form. Recently, in a reckless moment, a decision was made to use this simplified reporting system for the first time.

The dictation that followed told of a patient with a solitary lung lesion, a negative bronchoscopy, and an excised scalene node which was diagnosed as a granulomatous lesion and which, by special stains, was found to be due to acid fast bacilli. The patient was then treated with streptomycin, PAS and INH. A subsequent thoracotomy and wedge resection was done and the pathology again indicated a granuloma due to acid fast organisms. Following dismissal from the hospital, the patient resumed medical management under the care of her personal physician.

A week or so after this dictation, a letter was received from the insurance company expressing thanks and enclosing "an uncorrected copy for your records." The following is an exact copy of that report:

This patient was under my care and was first seen by me in consultation in June 1970. She had had an xray a solitary lesion of the right lower lobodemong (phonetic) and enlarged lymph gland in right cut-

Long articles take the place of two shorter ones. We strive to present timely information of interest to the highest possible proportion of readers. Keep those articles coming in; short, concise, informative, and of interest to the majority. Yours may be next.

We appreciate the tremendous support we have had from the physicians of Iowa. We will seek to live up to this support. We hope you will take pride in your medical journal. — M.E.A.

ratricitia (phonetic) area. She was ? and the lymph glands right cutratricitia (phonetic) glands were excised. ? was essentially negative grossly ? were taken. The pathology report indicated that the lymph node was "granulome (phonetic) disinformation, adalogy (phonetic) undetermined, with fibrosis (phonetic) of surrounding cell tissue." Special stains were done and the subsequent pathology report was as follows "lympgh node, right curtatricitia (phonetic) area granulome (phonetic) disinformation secondary to asafrasdisila (phonetic) with fibrosis (phonetic) surrounding tissue." The patient was then treated by Dr. George Fibe with pasma structamisan and IMS (phonetic). I saw patient again in January 1971 and at that time a wedge incision of granuloma was done. The granuloma was in the right lower lobe (phonetic). The pathology report was as follows "right lower lung containing large granuloma, calcsified (phonetic), due to asafras (phonetic) organism." The patient was dismissed from the hospital following this foracotomy (phonetic). I last saw patient in March, 1971 for a persative (phonetic) visit. She was getting along fine at that time and was under the medical care of Dr. George Fibe of Des Moines. Any further follow up on this patient must be referred to Dr. George Fibe of Des Moines.

Before seeing the transcription, a charge of \$8.00 was made for the dictated report. The \$8.00 charge is now seen to have been a mistake; it should have been much more. Where else could one get that kind of medical information for only eight bucks? — "Dr. Danile Crowley"

State Department of Health

HOSPICE — AN IDEA WHOSE TIME HAS COME

Death is a certainty for every one of us and, in most instances, there is little control over the immediate cause of one's death. There is some control possible, however, over the setting in which death occurs, especially when it is associated with a chronic disease. Today, some deficiencies in our system are quite evident. A century ago, death occurred at home with family and friends where the patient was surrounded and supported by a familiar environment. During the last several decades, the acute care hospital has become the locale of death. But most acute care hospitals are not truly equipped to minister to the dying patient because their goals are not geared to the terminally ill. Rather, they are dedicated to the treatment of the patient with every reasonable expectation the disease process will be reversed, the patient's health restored, and the patient returned to his normal activities.

Several years ago in London, Cicily Saunders, an unusual combination of a woman, who was a physician, nurse, and social worker, recognized the problems of dying in the acute care hospital and proposed the creation of a special institution devoted to the care of the dying patient and his family. She called her concept hospice, recognizing the role of the travelers way station so titled in medieval times. The hospice became a resting place on a journey towards death. Despite great opposition from her professional colleagues who could not understand the need for a special place to die, Dr. Saunders founded St. Christopher's Hospice in urban London. In the past ten years, its home care program and in-patient facility have become a model of com-

passionate care for the dying patient and family.

The corner stone of the hospice philosophy is support of the patient physically and psychologically. Relief of pain, for example, has been an area of concern to the hospice and by skillful manipulation of readily available drugs, patient comfort can be obtained. When "nothing more can be done," there is always something that can be done. Not with surgical procedures, chemotherapy, or radiation therapy, in the patient with advanced cancer, but with the simple facts that good nursing care so often overlooks. Oral nutrition that is appealing to the eye, the frequent application of a clean dressing over a foul smelling open wound, dry sheets in the presence of repeated urinary and fecal incontinence. Such skills are nothing new, and should be part of every health professional's job, but in the busy hospital they are often overlooked or minimized.

The dying patient is filled with fear, particularly of abandonment by physician and family, and needs special attention. The usually pressured and busy practitioner cannot or will not devote enough effort to something as simple as holding the hand of his dying patient to help him attain peace of mind. Physician withdrawal often takes place, but the patient is usually keenly aware of what is happening and the sense of desertion is destructive. The family of the dying patient is an integral part of the dying process, but had not truly been recognized until the hospice movement emphasized its importance. Hospice personnel become intimate with the patient and family at an early stage and their involvement with the patient's care can offer them support through this period of massive psychological ordeal. Their contacts with the family continue after the patient's death. The rigors of separation from

loved ones create depression, often leading to drug or alcohol abuse. The high incidence of organic illnesses in the surviving spouse is now understood and can be controlled in many instances by active intervention during the period of bereavement by interested, understanding, and sympathetic individuals.

Much of the care can be given at home and a home care program, an integral part of the hospice in London, has also been a part of the hospice program in New Haven, Connecticut, since the early 1970's. Currently, some 60 patient families are being given care in New Haven and the surrounding area by a full staff of physicians, nurses, social workers, and clergy available on a 24 hour basis. The time does arrive in many instances when, for a variety of reasons, home care is no longer possible and a hospice in-patient facility becomes necessary.

Hospice, Inc. in New Haven, Conn. currently is building the first free standing facility in the United States devoted exclusively to hospice care. While there have been other institutions in the U. S. for many years devoted to caring for the terminally ill patient, most of them have been custodial in character rather than rendering care within the hospice concept. They are attempting to minimize both anxiety and uneasiness for both patients and visitors. The fear of abandonment and desertion by staff and family is minimized by making the patient areas multi-bed units rather than

the single room which is so popular in current hospital construction. The staff is easily visible over low between-bed partitions, but privacy can be assured when indicated by judicious use of screens and curtains. The patients are encouraged to keep in touch with the rest of the world by allowing unlimited visiting hours and even children may visit at any time. An outdoor garden is planned for easy access. Even inclement weather will not destroy the view, since the windows in the patient area will open onto the greenhouses running along the length of the building. One story construction eliminates many problems encountered in multi-story buildings. A non-denominational chapel accentuates an important role in care of the dying patient and is available even to those patients confined to bed. The people at Hospice, Inc. say "while people may be afraid of this as a death house it's full of people who are living. They are at the end of their life, but they are living."

It's obvious there is a need for the kind of care that hospice offers in America. To meet this need many hospices have been started and a national hospice organization has been activated to coordinate activities which now span the continent. The individual aspects of hospice care have been known by doctors and nurses for a long time but only recently has it been possible to develop an integrated program and that is imperative if the best patient care possible is to be delivered.

FAVORABLE FIGURES

The overall rate of inflation increased by 1.1% in April, more than twice the rate of increase in the medical care component of the Consumer Price Index. For the third straight month the all-items index of the CPI reached

1% or higher. The medical care component increased 0.5% in April. Physicians' services rose 0.7% and hospital room charges rose 0.3%.

During the past three months the all-items index rose at an annualized rate of 14%, while the medical care index went up 7.8%. Over the past 12 months the all-items index rose 9%. The annualized rate of increase in physicians' services was 8.1% for the past three months and 8.9% for the 12-month period.

May 1979 Morbidity Report

Disease	May 1979 Total	1979 to Date	1978 to Date	Most May Cases Reported From These Counties
Amebiasis	8	47	76	Boone, Polk
Brucellosis	0	2	9	—
Chickenpox	1279	6532	4861	Scattered
Cytomegalovirus	2	4	12	Johnson
Eaton's Agent infection	1	25	73	Polk
Encephalitis	2	7	3	Dubuque, Johnson
Erythema infectiosum	309	792	43	Pottawottomie, Scott
Gastroenteritis (GIV)	1406	12358	12656	Scattered
Giardiasis	2	14	11	Boone
Hepatitis, A	15	75	68	Johnson, Polk, Scott
Hepatitis, B	6	35	42	Scattered
type unspecified	6	23	36	Scattered
Herpes simplex	6	32	39	Scattered
Infectious mononucleosis	72	326	587	Jones, Linn, Story
Influenza-like illness (URI)	3060	39098	38545	Scattered
Meningitis				
aseptic	1	13	0	Dubuque
bacterial	10	53	23	Polk, Scott
meningococcal	0	5	10	—
Mumps	30	207	108	Des Moines, Johnson, Polk
Pertussis	0	1	0	—
Robies in animals	16	74	58	Harrison, Marshall, Shelby
Rheumatic fever	0	8	22	—
Rubella (German measles)	5	48	25	Black Hawk, Cloy, Cloyton
Rubeola (measles)	0	14	49	—
Salmonella	15	61	54	Black Hawk, Cerro Gordo, Linn
Shigella	8	32	11	Polk
Tuberculosis				
total ill	5	35	46	Scattered
bact. pos.	3	31	34	Cherokee, Tomo, Woodbury
Venereal diseases:				
Gonorrhea	405	2338	2138	Scattered
P. & S. Syphilis	2	20	20	Clinton, Pottawottomie

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Adenovirus — 1, Pottawottomie, 2, County Unknown; Rocky Mountain spotted fever — 1, Pottawottomie, 1, Warren; Scarlet Fever — 2, Des Moines; Psittacosis — 1, Colhoun; Filariosis — 1, Dubuque.

HAND SYMPOSIUM

The Third Annual John R. Sebold Memorial Hand Symposium, sponsored by Bethesda Lutheran Medical Center, a seminar for primary care physicians, surgeons, nurses, occupational and physical therapists, will be held Friday, September 28, 1979 in the O'Shaughnessey Education Center at the College of St. Thomas in St. Paul.

The featured speakers are:

Richard Smith, M.D.
Chief of Hand Surgery Services
Massachusetts General Hospital
Boston, Massachusetts

Joseph Kutz, M.D.
Clinical Professor of Surgery
University of Louisville
Louisville, Kentucky

Allen Van Beek, M.D.
Associate Professor of Plastic
and Reconstructive Surgery
University of Southern Illinois
Springfield, Illinois

Application has been made for Category I credits, American Medical Association, American Academy of Family Practice and Minnesota Nurses Association continuing education credit.

There will again be an afternoon workshop for physical and occupational therapists to emphasize rehabilitation and splinting methods for diseases and deformities in the hand.

Diane Accurso, O.T.R.
Pat Schober, O.T.R.
Bethesda Lutheran Medical Center

For information on registration contact Tim Hanson, Associate Administrator, Bethesda Lutheran Medical Center, 559 Capitol Boulevard, St. Paul, Minnesota 55103, (612) 221-2395.

About IOWA Physicians

Dr. Roger I. Ceilley, former assistant professor of dermatology and director of dermatologic surgery and Mohs' chemosurgery at U. of I. College of Medicine, recently joined **Dr. John G. Thomsen** to practice dermatology in Des Moines. Dr. Ceilley received the M.D. degree and had his dermatology residency at U. of I. College of Medicine. . . . At recent annual meeting of the Iowa Society of Anesthesiologists, **Dr. Jackson D. Ver Steeg** was named president and **Dr. Marvin Silk**, secretary-treasurer. Both are Des Moines physicians. . . . **Drs. L. E. Boeke** and **D. A. Freed**, West Union, and **Dr. W. E. Owen**, St. Ansgar, were recognized recently for their service to medical school students at the Mayo Clinic. Drs. Boeke, Freed, and Owen serve as preceptors in the Mayo family practice residency program. . . . **Dr. Michael S. Chandra**, Sioux City, has been named a fellow of the American College of Cardiology. . . . **Drs. Beamer Breiling**, **Arno L. Jensen**, **Thomas J. Schueller** and **JoLynn Glanzer**, all Cedar Rapids physicians, participated in a recent CR public information program on "Taking the Fear Out of Cancer." . . . **Dr. John Rhodes, Sr.**, Pocahontas, has been named to the Long Range Planning Committee of the Federation of State Medical Boards. The appointment was made at the recent Congress on Medical Education in Washington, D. C. Dr. Rhodes is chairman of the Iowa State Board of Medical Examiners.

Dr. A. R. TouVelle, Bettendorf, has been named a diplomate of the American Academy of Family Physicians. . . . **Dr. William B. Galbraith** has been named president of the Linn County Medical Society; **Dr. John H. Lohnes**, president-elect; **Dr. Marian Barnes**, vice president; and **Dr. John Huston, Jr.**,

secretary-treasurer. All are Cedar Rapids physicians. . . . **Dr. Robert M. Lang**, Ottumwa, was guest speaker at a recent meeting of the Quad Counties Diabetes Unit. Dr. Lang spoke on eye troubles and diseases of the diabetic. . . . **Dr. Carl Rouse** joined the Leon Clinic in Leon June 1. Dr. Rouse was formerly associated with **Dr. L. C. Hermann** in Chariton. . . . **Dr. Peter Marcellus**, Creston, has been elected an at-large provider member to the Sub-area 4 Advisory Council of the Iowa Health Services Agency. . . . **Dr. S. W. Williams, Jr.**, Maquoketa, was guest speaker at a recent meeting of the Jackson County Business Association. Dr. Williams spoke on "Alcoholism and How It Relates to Your Business." . . . **Dr. Stuart Winston**, Des Moines neurosurgeon, spoke at a recent meeting of the Epilepsy Affiliate Division — Iowa Chapter. . . . **Drs. John Kelly**, Spencer, **Donald Wolters**, Estherville, and **Gerald Wieneke**, Emmetsburg, were program participants at recent family medical update seminar in Okoboji. The session was sponsored by Creighton University School of Medicine.

Dr. Howard B. Latourette, professor of radiology at U. of I. College of Medicine, was guest speaker at a recent conference for clergy at the Burlington Medical Center. The Conference was sponsored by the service and rehabilitation committee of the Iowa Division, American Cancer Society. . . . **Dr. Richard L. Vaught**, Sioux City, has been accepted as a member of the International Society of Cryosurgery. . . . **Dr. Walter M. Block**, Cedar Rapids, was guest speaker at a recent continuing medical education program at St. Clare Hospital in Monroe, Wisconsin. Dr. Block spoke on "Cerebral Dysfunctions and Learning Disabilities of Chil-

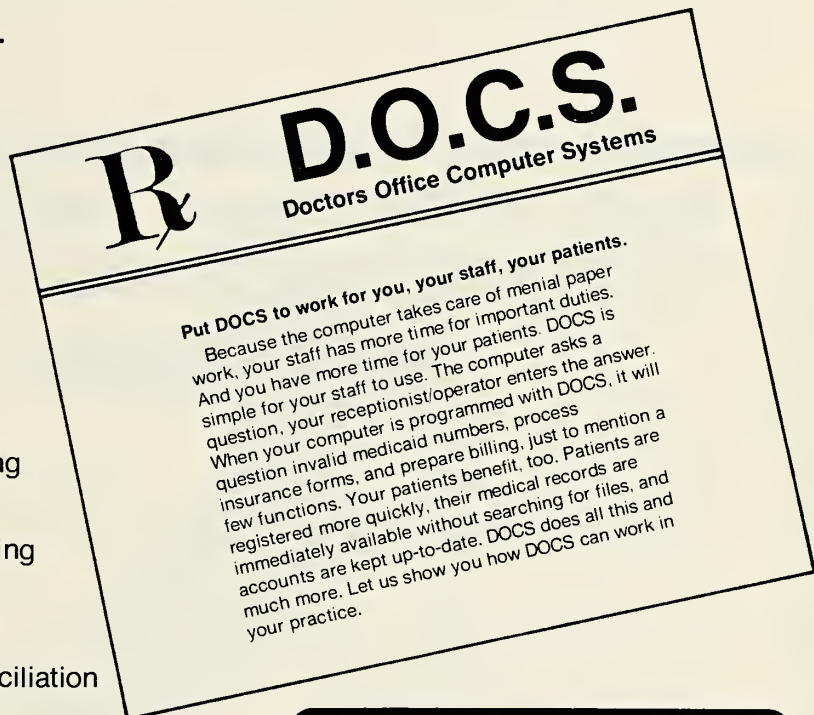
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dren." . . . **Dr. Robert C. Larimer**, Sioux City, was named "Internist of the Year" at recent meeting of the American College of Physicians in Iowa City. . . . **Dr. Samuel J. Foman**, professor in the U. of I. Department of Pediatrics, is the recipient of the 1979 McCollum Award of the American Society of Clinical Nutrition. Dr. Foman was cited for his work in infant growth and body composition. . . . **Dr. Charles Helms**, professor of infectious disease at U. of I. College of Medicine; and **Dr. LaVerne Wintermeyer**, Des Moines, state epidemiologist, were among guest speakers at recent meeting of the Clinton County Medical Society. The health officials discussed the 1975 outbreak of Legionnaire's disease in the Clinton area.

Dr. John Fieselmann, Des Moines, addressed the 1979 Spencer high school senior class at its recent baccalaureate. A 1964 graduate of Spencer high school, Dr. Fieselmann received the M.D. degree and completed his residency in internal medicine at U. of I. College of Medicine. He recently accepted a position on

the clinical teaching faculty of the internal medicine residency program at Iowa Methodist Medical Center in Des Moines. Dr. Fieselmann is the son of **Dr. and Mrs. George Fieselmann** of Spencer. . . . **Dr. J. Stuart McQuiston**, Cedar Rapids internist for 45 years, recently was presented the 1979 Founder's Award of St. Luke's Health Care Foundation. The annual award is given to an individual, organization or group that has had a significant long-term impact on health care in eastern Iowa. Dr. McQuiston is a past president of the Cedar Rapids Rotary Club and the Linn County Medical Society. He has participated in numerous health related committees and fund-raising campaigns. In April, he was named a life member of the Iowa Medical Society. . . . **Dr. Harold Moessner**, assistant professor in the U. of I. Department of Family Practice and director of the U. of I. Alcoholism Center, participated in a recent continuing education program for nurses, pharmacists, physicians and social workers in the Spencer area. Dr. Moessner spoke on "Contemporary Issues of Alcohol and Drug Misuse."

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Dr. Charles Jons and **Dr. Tom Smith, Jr.**, Ames physicians, were guest speakers at the April meeting of the Wright County Medical Society. Dr. Jons told the physicians of his medical experiences during recent trip to India and Dr. Smith gave a presentation on radical neck dissections. Dr. Jons also spoke on his extensive travel in India at a meeting of the Auxiliary of the Wright County Medical Society. . . . **Drs. John Justin, David Little** and **Gene Kuehn**, Mason City, **Drs. Herman Hein** and **Dwight Cruikshank**, Iowa City, and **Dr. Hans Dirksen**, Des Moines, were program participants in the Fourth Annual Symposium on Perinatal Care at Mason City. The Symposium was sponsored by the North Iowa Chapter, National Foundation March of Dimes, and the U. of I. College of Medicine. . . . **Dr. Mark Pabst**, Bloomfield, was guest speaker at a recent meeting of the Davis County Nurses Association. Dr. Pabst spoke on croup and ear infections.

Dr. Edward Annis, past president of the American Medical Association, was guest

speaker at a recent meeting of the Waterloo Rotary Club. Dr. Annis discussed the high cost of medical care and proposed less government intervention as a possible solution. . . . **Dr. James Clifton**, Roy J. Carver Professor in the Department of Internal Medicine at U. of I. College of Medicine, was guest speaker at a recent meeting of the Woodbury Medical Society.

Dr. Milton E. Barrent, Clinton physician since 1950, recently was named "Man of the Year" at Gateway Chamber of Commerce annual awards ceremonies. Dr. Barrent received the M.D. degree and completed his surgical residency at U. of I. College of Medicine. A Sioux City native, he founded the Bluff Medical Center. He has been Clinton health officer; medical director of the Clinton County Care Facility in Charlotte; director of the Gateway Chamber of Commerce; past president of the Clinton Art Association; and assisted in starting the Clinton Community College School of Nursing. He was recognized recently by the Iowa Football Coaches Association for his 29

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professional sports teams. The Executive Model is ideally suited for individual use and can be used at home or in the office. The equipment is so safe that many hospitals include the Total Gym in their physical therapy programs.

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years of service to high school athletes in Clinton. . . . **Dr. Johann L. Ehrenhaft**, professor of thoracic surgery and chairman of the thoracic-cardiovascular division of the Department of Surgery at U. of I. College of Medicine, is recent recipient of the Walter L. Bierring Award presented by the American Lung Association of Iowa at its annual meeting. . . . **Dr. Shiong Shiang Lee** has joined the North Iowa Medical Center in Mason City. Dr. Shiang will serve as chief of the pathology department. Prior to locating in Mason City, he was associated with Cook County Hospital in Chicago. Dr. Lee received his medical education in Taiwan and took post-graduate work at the University of Minnesota, Queen's Medical Center in Honolulu and the University of Alabama before joining the Cook County Hospital.

Dr. Barry S. Barudin, Davenport, has been named a fellow in the American Academy of Pediatrics. Dr. Barudin is a clinical assistant professor at the U. of I. College of Medicine

and is on the staff at Mercy and St. Luke's Hospitals in Davenport. . . . **Dr. James German**, Des Moines, and **Dr. Albert E. Cram**, Iowa City, were among program participants at the recent "Emergency Medicine '79" symposium in Sioux City. Dr. German is chairman of the Iowa Paramedic Council and Dr. Cram is director of the burn unit at University Hospitals. . . . **Dr. James T. Worrell**, Keosauqua, has been named chairman of the Van Buren County Board of Health. . . . **Dr. Kent Weinmeister** will assume the medical practice of **Dr. Clayton W. Clark** in Nashua in August. Dr. Clark, Nashua physician for 33 years, recently announced the termination of his practice following a heart attack this spring. Dr. Weinmeister received the M.D. degree at the University of Illinois and recently completed a family practice residency in Davenport. . . . **Dr. Linda Bickerstaff**, surgeon, has joined the medical staff at the Winneshiek County Memorial Hospital in Decorah. Dr. Bickerstaff is the wife of **Dr. H. V. VanPeenan**, pathologist at the hospital.

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AIR FORCE. HEALTH CARE AT ITS BEST.

Dr. Charles J. LaTendresse, Grundy Center, recently was named a board certified surgeon by the American Board of Surgery. Dr. LaTendresse is associated with the Family Health Center. . . . **Dr. Charles E. Robinson** has joined the family practice medical staff at the North Iowa Medical Center in Mason City. A private practitioner in Brooklyn, New York, for many years, Dr. Robinson recently relocated in the Mason City area. He received the M.D. degree at Cornell University Medical College in New York.

Emmetsburg in 1919. He was a charter member of the Emmetsburg Rotary Club and life member of the Iowa Medical Society.

Dr. Wallace H. Longworth, 79, Ames, died May 9 at Boone County Hospital. Dr. Longworth received the M.D. degree at U. of I. College of Medicine and interned at St. Luke's Hospital in Chicago. He began his practice of medicine in Boone in 1930 and upon his retirement in 1969 moved to Ames. Dr. Longworth was chief of staff at the Boone County Hospital; senior partner of the Family Practice Clinic in Boone; and for many years was division surgeon of the Chicago and Northwestern Railroad and chief surgeon of the Fort Dodge, Des Moines and Southern Railway. He was a past-president of the Boone School Board; director of the Boone YMCA; historian of the Boone County Medical Society and co-chairman of the Historical Committee of the Iowa Medical Society. During his retirement years, he wrote, "A History of Medicine in Boone County."

DEATHS

Dr. Harold L. Brereton, 93, longtime Emmetsburg physician, died April 13 at the Emmetsburg Care Center. Dr. Brereton received the M.D. degree at Rush Medical College in Chicago and began his medical practice in

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Criticism Misplaced Says IMS President

I think perhaps everything worth saying about health cost has been said by others. For me to address the subject may be a kind of rhetorical overkill. But I find I cannot remain silent when physicians are called the single responsible source of inflated health costs.

Although less than 20% of the 160 billion dollars in national health spending covers payment for physicians' services, it has been customary among the popular essayists on health policy to place full cost responsibility on the physician. They say he controls hospital admissions and the prescription of drugs and services. This simplistic argument ignores the fact the vast majority of diseases and injuries requiring hospitalization could have neither been prevented nor caused by the physician. Nor does the physician control the charge for use of the emergency room at \$25, the coronary care room of \$500, or the several hundred dollars worth of equipment packs used in the operating room. These are incurred even before the doctor performs the service for which the patient enters the facility. These high expenses result from inflationary factors unrelated to medical practice.

In actual fact, where physicians have administrative, as well as professional control of medical care, namely in the

"doctor's office," medical services are rendered at rates substantially lower than in any other health care facility. The minimum average fee for an office visit is between \$10 and \$15 depending upon the region of the country. This compares to the \$50 plus fee for similar services rendered in a hospital outpatient clinic or emergency room. When one considers the average office overhead is 40%, physicians have shown great constraint in the face of run-away inflation.

It is time society gets off the doctor's back and directs attention to the real cause of high medical costs — the cost of the non-professional side of medical care driven up by the uncontrolled inflationary factors of our economy.

There is no denying hard-working physicians have benefited from the heavy demand for health care, but their 12% personal share of the total health bill, is the smallest it has been in modern medical history. It can only be one of the lesser factors contributing to the high cost of health care.

Paul M. Seebohm M.D.

Paul M. Seebohm, M.D.

IOWA Medical Miscellany

IMS MEMBERSHIP KEEPS GAINING . . . As of mid-year, 1979 membership in the Iowa Medical Society had surpassed the total of last year. In June total membership was 2,823 compared with 2,755 for all of 1978. Dues-paying members numbered 2,392 at mid-year in contrast to 2,360 for all of last year.

WORKERS' COMP AUDIT . . . Field auditors for Casualty Reciprocal Exchange are now contacting those physicians' offices and clinics that participate in the Workers' Compensation Plan which is available to IMS members. This audit is necessary to calculate the earned savings for the past year and to make the distribution of these funds.

EXPECT PLAN PRESENTATION . . . The plan for an Iowa Medical Society Impaired Physician Assistance Program is expected to be presented to the IMS Executive Council August 29. The plan is the product of extensive consideration by an ad hoc committee of the Society. It was reviewed by the committee with the State Board of Medical Examiners in July.

ON DRUG HANDLING . . . A July 5 Attorney General's opinion issued in response to an inquiry from the Board of Pharmaceutical Examiners indicates the dispensing of a medication is not a delegable task and is restricted to either the pharmacist or the physician. No opportunity has been available for Society review of the opinion as this is written.

MEMBERSHIP HEARING . . . The IMS Judicial Council is scheduled to hear on appeal this month a request for membership which has been denied at the county medical society level. The August meeting of the Council is set for the 29th.

GROUP COVERAGES . . . The IMS attempts to provide a variety of group benefits for interested member physicians. A summary of the various insurance coverages is provided on page 322A of this issue. Included is an additional life insurance plan which has been added in recent months. Information on any of these coverages is available from IMS Headquarters.

MARIJUANA USE . . . Deliberate steps are being taken by the Board of Pharmaceutical Examiners to implement the new Iowa law to allow the use of marijuana for limited medical purposes. The Board expects to hold an August 20 public hearing in Des Moines on rules needed to implement the law. The law creates a medical advisory body to advise and counsel the Board of Pharmaceutical Examiners. The IMS has been advised members of this committee will be selected from nominees submitted by the Society. The program must have a qualified clinical investigator and must be approved by the FDA.

COUNCILOR REVAMPING . . . The 1979 IMS House of Delegates approved an organizational plan providing for two councilors per Iowa congressional district; this action was referred to the Society's Executive Council by the House for further development of the redistricting process and to determine the councilor election activity to be followed by the 1980 House of Delegates. A request is being made by IMS President Seeborn for the Judicial Council to develop these recommendations for submission to the Executive Council.

MMIS . . . See this issue's *Question Box* feature for amplification on the current implementation of the Iowa Medicaid Management Information System. This is on page 311.



The Question Box

by DON HERMAN

MEDICAID MANAGEMENT INFORMATION SYSTEM

Mr. Herman is manager of the Medicaid Management Information System (MMIS) unit in the State Department of Social Services.

Describe MMIS briefly.

The Medicaid Management Information System (MMIS) is an automated Medicaid claims processing and reporting system originally developed by the Department of Health, Education and Welfare (DHEW). Any state Medicaid program implementing the system to the satisfaction of a DHEW "certification team" will receive increased federal financial participation for the operational aspect of their Medicaid program. Thus far, 23 states have received "certified" status from DHEW for their MMIS.

What is the basic goal of the MMIS?

Obviously, we want to qualify for the increased federal financial participation from DHEW. More importantly, however, we want a system that aids the Iowa Medicaid program in being responsive to the needs of our clients and the providers serving those clients while providing maximum administrative efficiency.

What are the main benefits to Title XIX providers?

Due to the increased complexity and sophistication of medical procedures being per-

formed today, any Medicaid claims payment system must change to keep pace. The MMIS will use a more widely accepted procedure coding scheme (CPT-4), accept machine billings and process claims more accurately and efficiently. A greater degree of internal claim control will decrease the incidence of claims requiring resubmission.

Also worthy of mention is the remittance advice which will accompany the providers payment. This new advice will address all claims the provider has submitted as opposed to only those which have been paid. This will enable providers to better control accounts receivable.

What is the schedule for implementation?

The new MMIS claim form to be used by physicians was implemented July 1. This was done to allow for a gradual phasing out of the old forms. The MMIS will begin processing claims October 1, 1979.

Is explanatory information being made available?

Yes. We have prepared an entirely new physicians' manual outlining Medicaid policy, coverage of physician services, how to complete claim forms and where to obtain assistance when needed. This manual will be distributed in mid August.

Additionally, the carrier for the Iowa Medicaid program, Blue Cross and Blue Shield of Des Moines, will be conducting a series of workshops on MMIS. These workshops will take place in August and September. A schedule will soon be sent out giving dates and locations of those workshops.

Educationally Speaking



by R. M. CAPLAN, M.D.

THE TEACHABLE MOMENT

Educators, and practically anybody else who would give it a little thought, have long realized there are times when one is likely to learn relatively well, and other times when nothing seems to "stick." That circumstance of optimum receptivity is often called the "teachable moment." Anybody who seriously wants to learn, or any teacher devoted to achieving maximum learning in students, would like to arrange for *all* instruction to happen at the teachable moment. But since Utopia lies far away, another approach to the matter is to try to proliferate teachable moments so they happen more frequently. Naturally people vary — some have teachable moments arise in rapid sequence, while with others the frequency is less — it's analogous to individual variation in frequency of breathing, heartbeat, or sexual activity.

I recently experienced a teachable moment. In truth it lasted, regrettably, for a good deal more than a moment. I say "regrettably" because it occurred in relation to my giving testimony in a malpractice suit, and was highly uncomfortable. Mind you, I don't recommend this kind of circumstance as a prod to your

motivation to learn, but let me promise you that it certainly does wonders in focusing your concentration and making you desire to read and learn new information.

The essence of the teachable moment is that, just then, something has caused the learner to *feel a need*. Generally that relates to having some responsibility. In the case of malpractice testimony the need to be properly informed is obvious. It is similarly obvious for physicians as they go about problem-solving and patient care. These relationships of learning to responsibility and to a need to know help explain why so many professional continuing educators are less than enchanted with so many of the usual continuing education programs. We may arrange for the presentation of much information that may be true and useful in its place, stated by excellent faculty in an interesting fashion, but it is being presented at the wrong *time*. It is not the teachable moment. I don't think anyone knows what proportion of the information will "stick" when it is delivered at some other time, in comparison to being delivered at the teachable moment. But perhaps this idea of the teachable moment explains more than anything else why continuing education needs to be available promptly, close to home, and in relation to specific patient problems. A role of the CME director is to help you identify the educational needs in a timely fashion, and help you get at suitable learning resources.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

KIDNEY MEETING

September 7, 8 and 9 are dates of the tenth annual meeting of the Kidney Foundation of

Iowa at the Savery Hotel in Des Moines. Various scientific presentations are included on the Saturday and Sunday portions of this late summer meeting.

A Thought On Real Estate Investment: **Pheasant Ridge**

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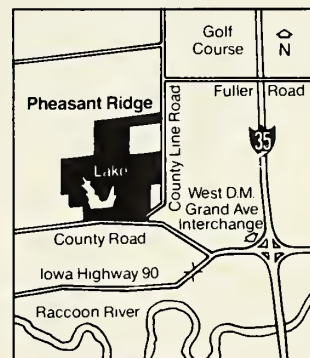
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MEDICAL MISCELLANY

IMS HEALTH PLANNING EVENT . . . As requested by the 1979 IMS House of Delegates, the Society is continuing and increasing its efforts to gain physician understanding of and participation in health planning activity. To this end, an IMS health planning briefing has been set at the Society for Thursday, September 27 for physicians who are active or interested in this important topic. Future IMS activity and strategy will be discussed at this September 27 session.

IVCCC PROGRESS . . . The Iowa Voluntary Cost Containment Committee has 82.3% of the state's hospitals under its umbrella; this includes 84% of the hospital beds and 98% of Iowa hospital expenses. Beginning in July, the IVCCC increased the reporting activity of its certified facilities. It is now required that monthly data reports be submitted as well as evidence of an active hospital cost containment committee.

MORE ABOUT AETNA DIVIDEND . . . This month or next physician participants in the IMS/Aetna Liability Insurance Program will be receiving additional dividend checks totalling \$240,329. This is the second administrative dividend paid this year and will average 7.6% of premium. Society members covered by the program are between 975 and 1,000 in number.

PA EMERGENCY TRAINING . . . Increased availability and quality of advance emergency medical care in rural Iowa is the goal of a new instructional program. Called the first of its kind, this educational effort for physician's assistants is a combined program of the U. of I. Physician's Assistant Program and the Emergency Medical Services Learning Resources Center. The first 8-week training session under the program will begin in January with 10 participants. A three-year \$308,419 grant from the Robert Wood Johnson Foundation will support the project.

IFMC INVOLVED . . . HEW has chosen the Iowa Foundation for Medical Care to be part of a national assessment of the impact of medical care evaluation studies on the quality of care. This is part of a total effort to examine PSRO effectiveness.

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Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychologic dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdose. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: *Cardiovascular:* Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. *Central Nervous System:* Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. *Gastrointestinal:* Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. *Allergic:* Urticaria, rash, ecchymosis, erythema. *Endocrine:* Impotence, changes in libido, gynecomastia, menstrual upset. *Hematopoietic System:* Bone marrow depression, agranulocytosis, leukopenia. *Miscellaneous:* A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSAGE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSAGE: Manifestations of acute overdose include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phenolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdose.

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References: 1. Citations available on request—Medical Research Department, MERRELL RESEARCH CENTER, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., D'Dillon, R.H., and Leyland, H.M.: A Comprehensive Review of Diethylpropion Hydrochloride. International Symposium on Central Mechanisms of Anorectic Drugs, Florence, Italy, Jan. 20-21, 1977.

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Thrombocytopenia Due to Quinidine Sensitivity

SAMUEL ROSA, M.D., and
ROSALIE B. NELIGH, M.D.

SPONTANEOUS HEMORRHAGIC disorders are as old as mankind. St. Mark (5:25-29) refers to a certain woman who had an issue of blood 12 years, and had suffered many things of many physicians, and had spent all that she had, and was nothing bettered, but rather grew worse, when she had heard of Jesus, came in the press behind, and touched his garment: For she said, if I may touch but his clothes, I shall be whole. And straightway the fountain of her blood was dried up; and she felt in her body that she was healed of that plague.

INTRODUCTION

Platelet disorders may result from an altered number or function. Thrombocytopenia and thrombocytosis (thrombocytosis) are among the disorders of platelet number. The most common serious bleeding problem involving platelets is thrombocytopenia. The normal

This is a case report of thrombocytopenia in a patient taking quinidine therapy for cardiac arrhythmia. Thrombocytopenia is referred to as the most common serious bleeding problem involving platelets.

platelet count ranges from 150,000 to 400,000 per mm. A platelet count of less than 100,000 per mm is generally considered to constitute thrombocytopenia. Spontaneous bleeding is common when platelet counts are between 10,000 and 20,000 per mm.

With counts below 10,000 per mm bleeding is usual and often severe. Spontaneous bleeding into the skin manifests as petechiae, purpuric spots or confluent ecchymoses. In the mouth, blood-filled bullae are almost pathognomonic. Bleeding may occur from any mucosal surface including the nose, uterus, gastrointestinal, urinary or respiratory tracts. The most serious site of spontaneous bleeding is the central nervous system where the hemorrhage may be fatal.

CASE REPORT

It is beyond the scope of this paper to consider the various types and etiologic

Dr. Rosa is in the private practice of general medicine in Neola, Iowa.
Dr. Neligh practices internal medicine in Council Bluffs, Iowa.

classifications of thrombocytopenia. Rather we will present briefly a case of thrombocytopenia due to quinidine sensitivity. A 43-year-old white housewife from Missouri, while visiting a daughter in Iowa in November, 1977, was seen with a primary complaint of bad taste in her mouth, blood filled bullae in her oral mucosa and lips. She also had petechiae and ecchymoses on her trunk, arms and legs. She had been discharged from her hometown hospital two days earlier.

It appeared from the history she had been hospitalized for cardiac arrhythmia. Two years prior she had noticed rapid heart rate, which was sudden in onset and cessation. These episodes were associated with shortness of breath, weakness and occasional dizziness. The cause of the rapid heart rate was not determined but the patient was given Inderal® 160 mg daily with apparent improvement of her symptoms.

Ten months before that last hospital admission the patient had been seen at the University of Missouri Medical Center for treatment of the rapid heart rate. The results of this examination were not available.

On November 23, 1977, the patient was discharged from the hometown hospital with a diagnosis of: (1) prolapsing mitral leaflet, and (2) ventricular arrhythmia secondary to number one.

Discharge therapy consisted of Inderal® 40 mg every 6 hours and quinidine 200 mg every 6 hours.

COURSE IN THE HOSPITAL

On November 25, 1977, the patient was seen in the clinic and admitted to a Council Bluffs hospital. The first laboratory findings were as follows: Hgb 13.3 gm, HCT 41, RBC 4.5, MCV 91, MCH 30, MCHC 33, WBC 7,300, platelet count: 4,000. Bleeding time, one minute. Activated coagulation time, five and one half minutes. Prothrombin-time patient 13, Control 12.5; SGOT, cholesterol, Alkaline Phosphatase, CPK, inorganic phosphorus, total bilirubin, all within normal limits. LDH was slightly elevated. EKG showed infrequent PVC's but otherwise was normal. BUN 9, chloride 96, potassium 4, sodium 136. PTT patient 27.0, Control 36.5; chest x-ray normal.

All prior medications were discontinued. The patient was started on prednisone 20 mg orally 4 times daily. Four units of platelet con-

centrate were given daily. A platelet count was ordered 4 hours after the last transfusion of platelet concentrate. The platelet count rose to 6,000 after the first 4 units of concentrate were infused. The following day they were up to 8,000. On the second hospital day the patient suddenly developed gross hematuria. She had received 8 units of platelet concentrate. Between the third and fourth day post admission she developed more blood-filled bullae in her mouth and her hematuria worsened. A sternal bone marrow aspirate revealed normal to slightly decreased megakaryocytes and decreased iron stores.

After 16 units of platelet concentrate were given the count rose to 55,000, but 12 hours later it dropped to 8,000.

It was concluded the platelets were being destroyed as soon as they were infused. Consequently the infusions were discontinued. Towards the end of the fourth admission day the patient suddenly became confused, showed marked pallor and tachyarrhythmia. One half hour later she was comatose. At this point we suspected exsanguination through the gastrointestinal tract, or intracranial hemorrhage. The patient started vomiting blood. Neutrophilic leukocytosis discovered at this point was probably secondary to steroid therapy.

In the intensive care unit the patient regained consciousness to a level we thought acceptable for an oral diet of 4 ounces of whole milk every hour and 30 cc of Maalox® on the half hour. Other measures included Tigan® 200 mg every 4 hours as necessary for nausea and 25 mg Premarin® IV. A lidocaine® drip was started at 2 mg per minute. Solu Medrol® 500 mg given in one dose. The monitor showed cardiac irregularity throughout her admission to ICU. A Pronestyl® drip was started at 2 mg per minute and Premarin® continued at 25 mg IV B.I.D. The following day, fifth day after admission, the patient stopped vomiting. A platelet count reported by the laboratory was ZERO. Aquamephyton® 1cc IV daily was administered, whole blood transfusions were continued and 4 units of platelet concentrate were also given at this time. The following day, sixth hospital day, the platelet count was 18,000 and the patient continued passing blood clots vaginally. On the sixth hospital day the platelets were 98,000. On the seventh day, they were 240,000, Hemoglobin 12.3 gm and the

vaginal bleeding stopped. The patient felt improved clinically, occasionally would pass vaginal clots which we thought was due to Premarin withdrawal. On the fourteenth day platelets were 830,000. Prednisone was reduced to 40 mg daily.

The patient was discharged on the 18th day after admission. She was advised to return to the hospital laboratory for a platelet count 2 days after discharge and wear a bracelet indi-

cating quinidine sensitivity. In time she returned to Missouri. From telephone conversations we learned she was doing well several weeks after discharge. Her platelets were within normal limits and she was under the care of a local cardiologist.

SUMMARY

The case of a 43-year-old white female with quinidine induced thrombocytopenia is discussed.

ON TREATING PHARYNGITIS

Recent survey findings of Iowa physicians show a variance between recommended protocol for the diagnosis and treatment of acute oral pharyngitis (AOP) and the anecdotal realities of medical practice.

Such was indicated from a mail questionnaire distributed to 1,300 Iowa general practitioners and pediatricians; family practice specialists were grouped with general practitioners.

The bulk of the medical literature on AOP recommends culturing all sore throats on patients above the age of two and withholding antibiotic treatment until culture results are known. The purpose of the survey was to see if Iowa practitioners vary from this protocol.

The questionnaire asked physicians to indicate their diagnostic and therapeutic habits as to AOP. The data received involved slightly over a quarter of a million cases of AOP annually.

Using Standard Linear Regression Analysis a substantial negative correlation ($r = -0.64$)

was found between percent of patients cultured and percent of patients treated with antibiotics. The more often patients were cultured in a given practice, the less likely they were to be treated with antibiotics.

Conversely, a positive correlation ($r = 0.62$) was discovered between patients diagnosed on the basis of physical exam alone and the percent of patients treated with antibiotics within a given practice. The more often AOP patients were diagnosed without the benefit of throat cultures the more often they were given antibiotics.

The average pediatrician was apt to culture more often and prescribe fewer antibiotics for AOP than the general practitioner. The average GP based therapy solely on the physical exam 60% of the time while the average pediatrician based therapy solely on the basis of the physical exam 23% of the time. Also, the GP prescribed antibiotics 56% of the time without culturing and the average pediatrician prescribed antibiotics 25% of the time without culturing.

The conclusions are (1) overtreatment of AOP in Iowa is more common when patients are managed without the benefit of throat cultures, and (2) generally, the diagnosis and treatment of AOP in Iowa varies widely from protocol recommended in the bulk of the pertinent medical literature.

This study was conducted by Noel T. Johnson and Patrick J. Crocker, senior students at the College of Osteopathic Medicine and Surgery, Des Moines, Iowa, and Richard Wilson, Ph.D., associate professor of microbiology, COMS.

A New Variant of Munchausen Syndrome: Pregnancy Complicated By Urinary Tract Infection

SISTER JEFFREY ENGELHARDT, OSF, M.D.

Sioux City, Iowa

EMERGENCY ROOM or hospital-based physicians must be alert to the patient who practices self-mutilation and deception to feign illness and gain hospital admission. On the other hand, the primary care physician must be familiar with the hypochondriac, the malingerer, the hysteric, the dependent patient. This case report will remind Iowa primary care physicians of the Munchausen Syndrome, a chronic fictitious illness or hospital addiction.

This psychiatric illness¹ is named for Baron Karl F. H. von Munchausen (d. 1797), a German officer in the Russian Service, who reputedly wrote a travel book full of extravagant fictions. The syndrome received this eponymic designation in 1951 from Richard Asher.²

Subjects of Munchausen Syndrome (1) regularly seek emergency medical help for alleged acute illness, (2) give a plausible clinical history that is later found to be false, (3) demand immediate hospitalization,³ (4) show evidence of many previous hospital procedures, especially surgical scars, (5) depart from the hospital

Individuals afflicted by Munchausen Syndrome feign illness and seek extensive medical help. Described here is a person with 281 hospital days over a 7-year period, involving 23 admissions. Notation is made of 24 doctors being seen. Purpose of the paper is to remind Iowa physicians of this relatively rare malady.

against medical advice, (6) have a history of many hospitalizations and extensive travel, (7) lack any discernible motive,⁴ and (8) may frequently be hospital employees or medical professionals. The varieties of the syndrome increase as physicians learn of the problem. In recent years these variations have included: hematuria with renal stones;⁵ blood bank donor with hepatitis;⁶ self inflicted bruising;⁷ feculent urine in a 15-year-old male, the youngest case of Munchausen Syndrome;⁸ a simulated Wolff-Parkinson-White Syndrome with appropriate fictitious ECG changes;⁹ the famous "Major Munchausen," a 51-year-old black male with a French accent who claims to be SAC pilot Major F. and who has been reported numerous times in numerous places.¹⁰⁻¹² Now there is even Munchausen by proxy, a form of child abuse, wherein parents give fictitious histories for their children.¹³ The following case illustrates yet another situational category: urinary tract infection in an obstetrical patient seen by a family practice physician.

Dr. Engelhardt is a first-year family practice resident with the Siouxland Medical Education Foundation, Inc., Sioux City, Iowa.

CASE REPORT

A.M.D. is a 20-some-year-old married white female, reportedly gravida one, para zero at this writing. Her age is questionable. She has listed at least 6 dates of birth ranging from 1-14-53 to 1-14-56. On confrontation, she admitted to this physician she had lied about her age, alleging 1-14-53 was her real date of birth. She is an L.P.N. and has been employed in 2 hospitals in Sioux City.

Her long complex medical history in Sioux City began in July 1971. Since then she has had 23 hospital admissions for various medical, surgical and psychiatric reasons; 28 outpatient visits; listed 24 different physicians as her doctor; undergone surgical procedures requiring general anesthesia 5 times; and submitted herself to relatively risky diagnostic procedures on numerous occasions. On dovetailing her admissions, it became apparent on 2 different occasions, after being discharged by a physician from a hospital in the city, she was admitted to another hospital by another physician for another complaint on the same day!

Over half of her admissions were for psychiatric or neurologic reasons: anxiety, depression, suicidal gesture, hysteria, conversion reaction, psychoneurosis and psychogenic seizures. During the workup of the seizures, she underwent several lumbar punctures, carotid flow studies and carotid angiograms. Only once was the diagnosis of Munchausen Syndrome even mentioned in the differential diagnosis.

Frequently, she focused on intraabdominal problems. These accounted for four of her admissions and two surgical procedures. In retrospect her July 1971 admission is questionable. She complained of right lower quadrant pain. Objectively, she was afebrile and had a WBC of 9,400. Upon admission she "spiked" a temperature of 102°F. (On subsequent admissions she admitted she changed thermometers to have fictitious fevers.) Surgery showed an appendix "not grossly inflamed" and microscopically "free of inflammation." Several times she was admitted to evaluate complaints relative to her gall bladder. Usually her gall bladder failed to visualize on X-rays. Never was there documentation that she actually ingested the contrast material. Finally, in June 1977, she underwent cholecystectomy. The surgeon reported no stones were palpable. The gall blad-

der was opened and no stones were seen. It contained sludgy bilirubinate material.

At other times her main concern was her urinary tract. She would retain urine and require catheterization, often chronically for months at a time. Many times her urine would be teeming with *E. Coli*. Her urinary workups included 4 IVPs, infusion pyelogram, cystogram, cystometrogram and cystoscopy, all negative.

Orthopedic complaints were another favorite. She underwent bilateral patellar tendon transplants. At other times her orthopedic complaints were related to trauma. Once she dropped a bedpan on her foot and required internal fixation of a subluxed toe. Another time she was traumatized in an alleged car accident.

Her two most recent admissions were for pregnancy complicated by urinary tract infections. When she admitted she failed to have a prescription for Ampicillin filled after a urine culture showed more than 100,000 *E. Coli* sensitive to the drug, this physician admitted her to ensure compliance with drug therapy. To compile her history, voluminous charts were examined at all the Sioux City hospitals. Then the real nature of her illness became apparent. Psychiatric admission was advised. However, she signed out of the hospital against medical advice. She is pregnant with an EDC of mid-January 1979. She will have difficulty finding medical care. Physicians in the area should be advised that patients with the Munchausen Syndrome have been known to travel.¹⁰⁻¹²

DISCUSSION

This case has some likeness to one noted in the literature where a young man after hypospadias repair for a very real disorder became focused on an isolated hypochondriacal delusion that something was amiss with his genitourinary system.⁸ The patient reported in the Sioux City case was hospitalized for severe measles at age 2. However, she was discharged due to uncontrollable behavior. Frequently, Munchausen Syndrome can be related to maternal deprivation. Often, the subject seeks a repetitive relationship with a physician to act out the desired dependent-maternal relationship.¹⁴ This patient's mother, age 44, is a severe rheumatoid arthritic and has made excessive demands for the time and attention of the pa-

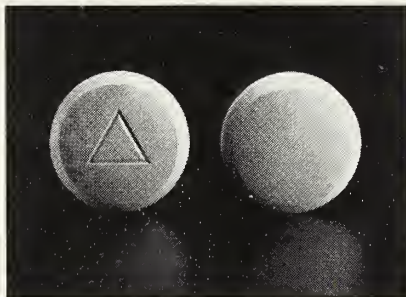
(Please turn to page 322)

The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally "expensive" and generic versions are relatively "cheap." To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only "expensive" brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: Generic options almost always exist.

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: Drugs account for a major portion of the rise in health care costs.

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: Government intrusions into the marketplace will save tax money.

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

tient, the eldest of 5 girls. Presumably, the patient learned from her mother how to gain attention with physical complaints. The patient's avocation as a licensed practical nurse provided enough information for her to be convincing.

The morbidity of this patient's illness is astounding. In 88 months she has spent 281 days in the hospital, averaging just over 3 hospital days per month. Her hospital bill, not including surgical, laboratory or radiologic fees, must be in excess of \$15-30,000. What happens if insurance or other third party payers do not foot the bill? What if her husband or family should charge that surgery was done unnecessarily? The medical, legal and economic aspects are staggering.

TREATMENT

Treatment of Munchausen Syndrome is difficult at best, because the nature of the illness is not well understood. What really motivates the Munchausen patient? A need for attention? A desire to outwit the medical profession? A dash of masochism? A fixed delusional system built around their complaints? Surely all of these enter into the motivation of the Munchausen patient but not one or all combined fully explain the puzzle.¹⁵ "The behavior of some of these patients seems so bizarre, tenacious, and self-destructive that it cannot be accounted for by secondary gain alone."⁸

As soon as a physician suspects the Munchausen Syndrome — which in this case would have been unlikely, if all the medical records had not been examined over a short time period, the traditional patient-doctor relation-

ship begins to weaken. "The resourcefulness of a deceptive patient may require an equally resourceful physician."⁵ The detective work necessary to establish the diagnosis may further weaken the patient-doctor relationship. Confrontation is essential, according to one study.⁸ In this case, it only precipitated the patient's exit from the hospital. Another study decries confrontation and suggests instead: (1) a tolerant, sympathetic attitude, and (2) arrangements for long-term supervision and psychotherapy by one or several physicians.⁴ Electroshock for concomitant depression and hypnosis may be helpful but not curative. This patient has undergone both hypnosis and behavioral modification during a five and one-half month admission in a state mental hospital. At least one case has responded favorably to psychotherapy.⁸ Munchausen patients have a psychiatric illness and deserve psychiatric therapy.

This report is not intended to point fingers at any of the physicians involved in the care of this patient. After all, this physician was duped for a time as well. The purpose of this report is simply to call Munchausen Syndrome to the attention of Iowa physicians.

ADDENDUM

Since the paper was written, the patient delivered a female infant on 1-15-79. It has also been brought to the attention of the author this woman has since sought medical help from two additional Sioux City physicians.

REFERENCES

The references noted in this article are available on request either from the author or from the JOURNAL OF THE IOWA MEDICAL SOCIETY.

RESTORING A DOCTOR'S OFFICE

A unique project has been undertaken by the Polk County Medical Society Auxiliary — that of relocating and restoring a doctor's office from the 1870's at the Living History Farms. The structure is to be moved from Polk City to the LHF Main Street just west of Des Moines.

The office is that of Robert B. Armstrong,

M.D., a general practitioner who lived from 1857 to 1905.

Approximately \$35,000 will be needed to complete the project — moving the building brick by brick. Tax-deductible contributions are invited from Iowa physicians. Please make checks to PCMSA-LHF/Polk County Medical Society Auxiliary/Living History Farms and send to Mrs. Robert Schulze, 4116 73rd Street Place, Des Moines, Iowa 50322.

IOWA MEDICAL SOCIETY INSURANCE SERVICES AVAILABLE TO MEMBER PHYSICIANS

On the following two pages is a summary of the insurance coverages which are available from the Iowa Medical Society. All member physicians are invited and encouraged to review this outline to see if and where any of these coverages may fill a void in or supplement an existing individual insurance program. This suggestion is directed particularly to those physicians who are new to membership in the Society.

The Committee on Member Services of the Iowa Medical Society is responsible for the periodic evaluation of these programs to determine their value and receptivity. It is the further duty of the Committee to consider and recommend appropriate new coverages.

Any questions or comments regarding these programs may be directed to the administrator as shown or to the Headquarters of the Iowa Medical Society, 1001 Grand Avenue, West Des Moines, Iowa 50265 (Telephone—515-223-1401; In-WATS—1-800-422-3070).

INSURANCE PLANS FOR

TYPE	COVERAGE	SPECIAL FEATURES
1. PROFESSIONAL LIABILITY INSURANCE PACKAGE	Provides Basic Professional of \$100,000/\$300,000 or \$250,000/\$500,000 (depending on classification); Premises Liability; Catastrophic Liability From \$1 to \$5 Million.	Occurrence Form, Guaranteed 3-Year Market, Possible Expense and Loss Dividends, Active IMS Role in Loss Prevention & Control, Right to Insurability Hearing.
2. INCOME PROTECTION (ACCIDENT AND SICKNESS DISABILITY)	Optional Amounts Up to \$300 Weekly (\$1,300 Monthly) and Benefit Durations Up to Lifetime for Accident and to Age 65 for Sickness. Program Automatically Includes \$1,000 Accidental Death & Dismemberment, Waiver of Premium, a Rehabilitation Program and Loss of Use of Hand or Hands Benefit. Future Increase Option Available.	Benefits Begin First Day of Disability for Accident and Earlier of Eight Day Disabled or First Day Hospital Confined for Sickness. Optional Plans Available With Benefits Beginning the 29th Day, 57th Day, 92nd Day or 183rd Day. Claims Paid Directly From Administrator's Office. Special Renewal Features and Conversion Option Automatically Included.
3. OFFICE OVERHEAD DISABILITY COVERAGE	Available From \$200 Monthly to \$2,000 Monthly as Reimbursement for Office Expenses (Rent, Employee Salaries, Utilities, etc.) Incurred During Insured's Disability.	Benefits Begin After Waiting Period of Either 14 Days or 30 Days With Benefits Payable Up to 24 Months. Premium Tax Deductible. Special Renewal Features and Conversion Option Automatically Included.
4. TERM LIFE INSURANCE (Bankers Life)	Available in Amounts From \$10,000 to \$100,000. Guaranteed Renewable and Convertible to Age 70. Special Plans Available for Members of IMS Auxiliary in Amounts From \$5,000 to \$25,000.	Individual Policies. Renewal Rate Guaranteed. Waiver of Premium. Double Indemnity. Full Conversion Privilege Any Time. Dividends Reduce Premium.
5. TERM LIFE INSURANCE (American Mutual)	Provides up to an additional \$100,000 in low-cost term life insurance benefits. Policies fully convertible after they have been in force one year. Benefits reduce 20% every 5 years beginning at age 50. Plan is renewable to age 70.	Waiver of Premium. Full conversion privilege after policy has been in force one year. A new member under age 65 of IMS may apply for one unit of coverage with guaranteed issue if application is made within 90 days of membership. Optional dependent coverage is available for members, spouse and children.
6. EXCESS MAJOR MEDICAL	Pays 100% of Eligible Expenses After \$10,000, \$15,000, \$20,000, \$25,000 or \$50,000 Deductible Is Satisfied. Once Deductible Is Satisfied Plan Pays Up to \$300,000 per Person.	10-Year Benefit Period. 36 Months in Which to Satisfy Deductible. Guaranteed Issue. Renewable for Lifetime.
7. HIGH LIMITS ACCIDENTAL DEATH AND DISMEMBERMENT	Accidental Death, Dismemberment, Loss of Sight, Permanent and Total Disability Feature. Available From \$25,000 to \$150,000—Wife & Family Coverage Also Available.	24-Hour, World Wide Coverage. Aviation Coverage as Passenger. 365 Day Coverage. Renewable to Age 70. No Medical Underwriting.
8. HOSPITAL/MEDICAL	Two-option Coverage Available to Physicians, Their Families and Employees. Excellent Benefits to Cover Both Hospital and Medical Services.	365-Day Comprehensive Hospital. 365-Day Blue Shield UCR. Nervous/Mental, Drug Addiction, TB and Alcoholism. Major Medical Optional.
9. WORKERS' COMPENSATION	Provides Workers' Compensation Coverage as Required by State Law. Approved Rates Are in Effect. Program Meets Employer's Obligations for Occupational Injuries to Employees.	Is a Savings Plan in That Dividends Are Paid Based on Experience. 35% Return of Premium Has Occurred With Higher Percentage Possible. Safety Counsel Is Provided.

IOWA MEDICAL SOCIETY MEMBERS

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INSURANCE COMPANY

ELIGIBILITY AND HOW TO APPLY

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611 Fifth Avenue
Des Moines, Iowa 50309

Aetna Life & Casualty
Hartford, Connecticut

All Members May Apply Through Local Aetna Agents, The Prouty Company or Des Moines/Omaha Offices of Aetna. Information Available From Des Moines Aetna—1-800-362-1809 or 515-244-5145.

The Prouty Company
2130 Grand Avenue
Des Moines, Iowa 50312

Commercial Insurance
Company
Newark, New Jersey

New Members Eligible for Base Amount of Coverage Regardless of Medical History, if Application Is Made in 90 Days of Membership. All Insurable Members Eligible Anytime Prior to Age 56. Coverage Continues to Age 70 for Active Members. Special Plan Available After Age 70. Apply to The Prouty Company—1-515-243-5255 or Toll Free—1-800-532-1105.

The Prouty Company
2130 Grand Avenue
Des Moines, Iowa 50312

Commercial Insurance
Company
Newark, New Jersey

Applicant Must Be in Active Practice, Under Age 60, and Member of IMS. Apply to The Prouty Company—1-515-243-5255 or Toll Free—1-800-532-1105.

The Prouty Company
2130 Grand Avenue
Des Moines, Iowa 50312

Bankers Life Company
Des Moines, Iowa

Any Active Member Under the Age of 65 May Apply. Apply to The Prouty Company—1-515-243-5255 or Toll Free—1-800-532-1105.

The Prouty Company
2130 Grand Avenue
Des Moines, Iowa 50312

American Mutual Life
Des Moines, Iowa

Any active member under the age of 65 may apply. New members may apply for one unit of coverage if under 65 with guaranteed issue if done within 90 days of membership. Apply to The Prouty Company—1-515-243-5255 or toll free (Iowa) 1-800-532-1105.

The Prouty Company
2130 Grand Avenue
Des Moines, Iowa 50312

Insurance Company of North
America
Philadelphia, Pennsylvania

All Members, Their Families and Employees. Apply to The Prouty Company—1-515-243-5255 or Toll Free—1-800-532-1105.

The Prouty Company
2130 Grand Avenue
Des Moines, Iowa 50312

Insurance Company of North
America
Philadelphia, Pennsylvania

Any Active Member Under the Age of 65, Spouse, and/or Family. Apply to The Prouty Company—1-515-243-5255 or Toll Free—1-800-532-1105.

Blue Cross/Blue Shield
Ruan Center
Des Moines, Iowa 50309

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Des Moines, Iowa

All Members, Their Families and Employees. Apply to Blue Cross/Blue Shield.

Casualty Reciprocal Exchange
Dodson Insurance Group
P.O. Box 559
Kansas City, Missouri 64141

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Management of Lithium Induced Diabetes Insipidus in Manic-Depressive Illness: A Case Report

RANDOLPH PAINE, M.D.,
KENNETH JUDIESCH, M.D., and
MARVIN JUNGLING, M.D.
Iowa City, Iowa

THE EFFICACY of lithium carbonate in the treatment of manic depressive illness is well documented.¹ In addition, lithium has been used to treat other affective disorders as well as schizophrenia, Huntington's Chorea, tardive dyskinesia, alcoholism, drug abuse, aggressive behavior and thyrotoxicosis.² This new popularity has revealed adverse effects on numerous organ systems, including a nephrogenic diabetes insipidus-like syndrome.³⁻⁶ The mechanism of this syndrome is uncertain and management of the complications is evolving.

CASE REPORT

A 71-year-old man was admitted to the hospital with lethargy and confusion. A history of manic depressive illness had existed for over 23 years.

Lithium carbonate therapy was initiated 5 years prior to admission with a dosage range of

This interesting case study is of a patient whose urine output was reduced only by curtailing his lithium dosage. The suggestion is made that this approach be tried before use is made of thiazides in the care of this syndrome.

900-1,800 mg daily. Serum lithium level range was 0.59-1.3 meq/L. During hospitalizations doses as high as 21 mg/d and serum levels of 1.7 meq/L were noted. The patient had never had polydipsia or polyuria and had no history of endocrine or renal disease. Previous BUN determinations ranged from 10.0-15.0% creatinines from 1.3-1.5 mg%, and urine specific gravities from 1.009 to 1.027. His 24-hour urine output was as high as 2,500 cc only once, and that was postoperatively.

Seven weeks prior to admission the patient was diagnosed as having benign prostatic hypertrophy and underwent a transurethral resection of the prostate with no complications. He had no signs or symptoms of mania or lithium toxicity with a dose of 1,800 mg/d and serum lithium level of 1.1 meq/L. Urine specific gravity was 1.010 and 24-hour output was less than 2,500 cc. he was discharged on the fifth postoperative day.

Four days after discharge he returned to the hospital with excessive energy and push of speech. There were no symptoms of polydipsia

The authors are associated with the Department of Family Practice, University of Iowa and Mercy Hospital, Iowa City, Iowa.

or polyuria. Serum lithium level was 1.7 meq/L and urine specific gravity was 1.005. He was treated with lithium carbonate 1,800 mg/d and haloperidol 1 mg tid for two weeks and discharged in stable condition on this regimen. One week later he was readmitted with symptoms of mania. There was no polyuria or polydipsia. Serum lithium level was 1.2 meq/L and urine specific gravity was 1.005. His condition was stabilized and he was discharged after 10 days on lithium carbonate 1,800 mg/d and haloperidol 6 mg/d.

Three days prior to the most recent admission he became lethargic and confused. Twenty-four hours before admission he became ataxic and incontinent and began to drool. Haloperidol was discontinued, but these symptoms persisted.

On admission his vital signs were normal with no signs of orthostatic hypotension. He was a slightly obese Caucasian with slurred speech. His main complaint was fatigue. The physical exam was remarkable for ataxia of gait and lingual dystonia, but he was not drooling. He had an increased A-P diameter of the chest with hyperresonance and coarse rales throughout the lung fields. He was oriented to person and place but not to time and was slow to respond to questions.

LABORATORY DATA

Admission laboratory studies revealed normal CBC and differential, serum electrolytes and serum studies for bicarbonate, glucose, BUN, bilirubin, alkaline phosphate, LDH, SGOT, Ca, P, Protein, albumin and cholesterol, with a uric acid of 8.7 mg% (nl = 2.5-8.0). Lithium level was 1.2 meq/L. Urinalysis revealed pyuria and bacteruria with specific gravity of 1.010, and culture revealed several organisms sensitive to sulfa. Chest x-ray was consistent with pulmonary emphysema without evidence of active disease. The EKG was normal.

The patient was thought to be recovering from haloperidol intoxication and the drug was withheld. Sulfamethoxazole was given for 10 days for urinary tract infection. His mental status gradually cleared over 3 days while on lithium carbonate 1,800 mg/d. Haloperidol was then reinstituted at 1 mg/d for insomnia and excessive talking. On the sixth day after admission he was still incontinent and was noted to have nocturia. Urinalysis was unremarkable

for pyuria or bacteruria and specific gravity was 1.008. The serum lithium level was 1.2 meq/L. Polyuria in excess of 6 L/24 hours was then discovered. Intake and output on three previous days had been 2-3 L/24 hours and 3-4 L/24 hours, respectively. Subsequently his intake was as high as 4.5 L/24 hours, and his output consistently greater than 5 L/24 hours for the next 6 days.

Skull x-rays and brain scan were unremarkable. A water deprivation test was performed, and in 13 hours he lost 3.4% of his body weight. Urine osmolality decreased from 313 to 205 mOsm/kg and serum osmolality increased from 293 to 303 mOsm/kg. Vasopressin 5 u was administered IM and polydipsia and polyuria persisted 4 days. Urine osmolality range was 181-228 and specific gravity was 1.007 or less.

Three days prior to discharge, lithium carbonate was decreased to 1,200 mg/d and haloperidol was decreased to 0.5 mg/d. On the day of discharge, intake was 2 L/24 hours and output was about 3 L/24 hours. Serum lithium level was 0.8 meq/L. Seven weeks after discharge, his mental status was stable and his output was 3,200 cc/24 hours with urine osmolality 287 mOsm/kg. Serum lithium level was 0.9 meq/L. He has been asymptomatic on this regimen for over one year with normal bladder control. Reproduction of the polyuria by increasing the lithium dose has not been attempted.

DISCUSSION

Several reports have demonstrated a nephrogenic diabetes insipidus-like syndrome which is reversible when lithium therapy is terminated.^{3, 6-8} The mechanism of this syndrome is unknown, but recent studies suggest that lithium causes a decreased responsiveness of the distal tubular epithelium and collecting duct to antidiuretic hormone.^{6, 9, 10} Unlike other toxic effects of lithium, this syndrome is thought to be unrelated to dose. It occurs at dosages and blood levels considered safe and develops at varied lengths of therapy without associated clinical features of lithium toxicity.^{3, 4, 11} It has also been noted that some patients with this syndrome have a partial response in urine concentration to parenterally administered vasopressin.⁴ No known interaction exists between the sulfonamides and lithium. Although lithium is known to increase

haloperidol toxicity, there is no known potentiation of lithium therapeutic effects or toxicity by haloperidol.¹²

Discontinuing lithium therapy may not be desirable in certain patients. Chlorothiazide, which is known to be effective in other forms of diabetes insipidus, reduces the urine output in this syndrome.^{6, 8, 11} This effect may be due to reduction of glomerular filtration which subsequently decreases renal clearance of lithium and results in increased serum levels.¹¹ Thus, prior to initiating thiazide therapy, it has been recommended the lithium dosage be decreased by 50% and then gradually increased to therapeutic blood levels when diuretic therapy has stabilized urine output.⁶

In our patient, a significant reduction in urine output (from 5-6 L/d to 3 L/d) was achieved with only the reduction of the lithium dosage (from 1,800 mg/d to 1,200 mg/d). The urine remained slightly hypotonic ($U_{osm} = 287 \text{ mOsm/kg}$). In previous reports of the use of thiazides in this syndrome, the actual urine

output achieved was no better (Table I) and in each case the urine remained hypotonic.

TABLE I

No. of Patients	Urine Output (L/d)		Reference
	Initial	Thiazide Treated	
1	9	3	6
1	5	2-3	8
3	6-8	4-5	11
1	5-6	3	Case Report

Therefore, it is suggested that reduction of the lithium dosage be attempted before initiation of thiazides in this syndrome. Perhaps the phenomenon is dose related and a response could have been obtained in the previously cited cases^{6, 8, 11} with a reduction of lithium dosage alone.

REFERENCES

The references noted in this article are available either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

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units, bacitracin zinc 400 units, neomycin sulfate 5 mg (equivalent to 3.5 mg neomycin base), special white petrolatum qs; in tubes of 1 oz and 1/2 oz and 1/32 oz (approx.) foil packets.

INDICATIONS: Therapeutically, (as an adjunct to systemic therapy when indicated), for topical infections, primary or secondary, due to susceptible organisms, as in: infected burns, skin grafts, surgical incisions, otitis externa, primary pyodermas (impetigo, ecthyma, sycosis vulgaris, paronychia); secondarily infected dermatoses (eczema, herpes, and seborrheic dermatitis); traumatic lesions, inflamed or suppurating as a result of bacterial infection. Prophylactically, the

ointment may be used to prevent bacterial contamination in burns, skin grafts, incisions, and other clean lesions. For abrasions, minor cuts and wounds accidentally incurred, its use may prevent the development of infection and permit wound healing.

CONTRAINDICATIONS: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components. Do not use in the eyes or in the external ear canal if the eardrum is perforated.

WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

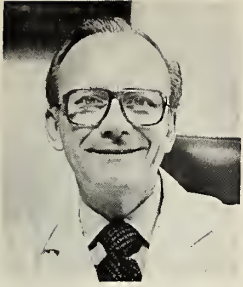
When using neomycin-containing products to control

secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching, it may be manifest simply as failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations, prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



Editorials

M. E. ALBERTS, M.D., Scientific Editor

10 COMMANDMENTS FOR PHYSICIANS

Iowa Methodist Medical Center in Des Moines has an active cost awareness/containment program being directed by Edward Hertko, M.D., president of the medical staff and director of continuing medical education. Recently, a series of 10 commandments were released by his office; a separate listing for employees, for patients, governing board members, third party payors and physicians.

The 10 commandments for physicians are:

1. Thou shalt review thy patients' hospital bills, in order to better understand total patient costs.
2. Thou shalt familiarize thyself with drug prices, consultant fees, lab and X-ray charges, thereby learning more about health care costs.

3. Thou shalt not be persuaded toward over reliance on tests; instead, rely more upon clinical judgment and not on diagnostic procedures only.

4. Thou shalt be more selective in ordering tests. Order tests as patients' problems become clearer.

5. Thou shalt teach cost control to student physicians.

6. Thou shalt look at costs on a cost-by-case basis.

7. Thou shalt make patients' records available to covering colleagues.

8. Thou shalt provide lab and X-ray test results to the physicians when referring a patient.

9. Thou shalt avoid late-week elective admissions. The weekend wait extends the patient's stay and increases their costs.

10. Thou shalt shop around for supplies.

NOW IT'S "OFFICIAL"

A popular magazine* featured an article several months ago about priorities in paying debts. The author analyzed various forms of debt and placed them in an order of payment priority. All forms of common family obligations were considered. Your guess on the priority of medical bills is correct if you put them last on the list. The logic of this priority order probably seems reasonable to the aver-

age person, but the reasons given were a bit presumptive. In fact, they seemed almost dishonest. Nonpayment of medical bills seemed to be encouraged for such action would cause no loss of credit or retribution in the form of penalties or interest fees.

The order of priority indicated in the article was based on three major factors: (1) Convenience of the debtor; to avoid discomfort or problems of harassment, (2) Cost; involving interest or late fees, and (3) Credit rating jeopardy. It was suggested physicians do not cause much of a problem for a considerable time after a bill is due. Only a few add late fees;

* Which bills should you pay first? *Family Circle*, February 1, 1979.



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EDITORIALS

(Continued from page 327)

interest is not charged; and seldom is credit information given to credit bureaus.

Physicians generally retain their own collection efforts, or provide discreet reminders on the statements. Often a year will elapse before a collection agency is brought into the picture. The author wisely suggests, however, that patients should discuss their financial problems with the physician when payments will be delayed.

The order of payment priority set forth in the article is:

1. Rent
2. Utilities
3. Mortgage payments
4. Car loans
5. Small loans with finance companies
6. Credit cards (Master Charge, Visa)
7. Travel and entertainment credit cards (American Express, Diners)
8. Department stores and retailers
9. Medical, dental and hospitals

Conclusion: Buy on credit, live it up, tear down your health, seek medical attention and pay the doctor if any money is left. — M.E.A.

CROSS COUNTRY ADVICE

Schedule cross country races on days when the temperature is no higher than 78 degrees, start the race at 8 a.m. or earlier, and have plenty of water for the runners to drink.

That admonition was given by two University of Wisconsin physicians to novice distance runners to help them avoid heatstroke in road races. The report of Drs. Peter G. Hanson and Stephen W. Zimmerman appeared in the July 13 JOURNAL OF THE AMERICAN MEDICAL ASSOCIATION.

Most problems came near the end of the race in the experience reported. This occurred when the runners tried to step up the pace for a fast finish. Various suggestions are made including a first aid station located every three miles along the running route.

June 1979 Morbidity Report

Disease	June 1979 Total	1979 to Date	1978 to Date	Most June Cases Reported From These Counties
Amebiasis	10	57	104	Boone, Polk
Brucellosis	0	2	9	—
Chickenpox	469	7001	5594	Scattered
Cytomegalovirus	2	6	15	Henry, Johnson
Eaton's Agent infection	3	28	86	Dubuque, Polk, Tomo
Encepholitis	3	10	3	Linn, Marion, Polk
Erythema infectiosum	279	1071	50	Pottowattomie, Scott
Gastroenteritis (GIV)	445	12803	12879	Scattered
Giordiosis	4	18	11	Muscotine
Hepatitis, A	23	98	84	Boone, Polk
Hepatitis, B	13	48	50	Johnson, Scott
type unspecified	3	26	40	Polk, Scott
Herpes simplex	5	37	48	Johnson, Polk Scott, Tomo
Herpes Zoster	1	1	8	Sioux
Infectious mononucleosis	37	363	641	Linn, Marshall, Story
Influenza-like illness (URI)	1171	40269	38858	Scattered
Meningitis				
oseptic	0	13	0	—
bacterial	11	64	23	Scattered
meningococcal	0	5	10	—
Mumps	13	220	121	Des Moines, Scott
Pertussis	0	1	0	—
Robies in onimols	16	90	68	Scattered
Rheumatic fever	2	10	24	Block Hawk, Scott
Rubello				
(Germon measles)	3	51	40	Cloyton, Des Moines, Washington
Rubeolo (meosles)	1	15	53	Poweshiek
Solmonello	12	73	65	Scattered
Shigello	5	37	19	Polk
Tuberculosis				
total ill	7	42	54	Scattered
boct. pos.	5	36	36	Scattered
Venereal diseases:				
Gonorrheo	405	2743	2583	Scattered
P. & S. Syphilis	3	23	23	Linn, Marshall, Muscotine

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Legionnaire's Disease — 1, Dickinson, 1, Tomo; Rocky Mountain spotted fever — 1, Block Hawk, 2, Johnson, 1, Plymouth, 1, Poweshiek, 1, Story, 1, Washington, 1, Woodbury; Scarlet Fever — 1, Des Moines; Polio (Paralytic) — 3, Buchanon; Typhus Epidemic — 1, Scott; Malaria — 1, Polk; Echovirus Type 4 — 1, Des Moines; Coxsackie B 5 — 2, Scott.

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About IOWA Physicians

Dr. Dennis Nitz joined Eckman Neurologic Associates in Sioux City in July. Dr. Nitz received the M.D. degree from the University of Nebraska School of Medicine and completed his neurology residency and EEG/EMG fellowship at the U. of I. College of Medicine. . . . **Dr. Roy W. Overton**, West Des Moines, was guest speaker at a recent meeting of the Fort Dodge division of the Izaak Walton League. Dr. Overton spoke on diseases caused by chemical pollution of the Love Canal in Niagara, New York. Dr. Overton recently received a Certificate of Merit Award from the Izaak Walton League for his years of work on Beaver Creek. He is current national co-chairman of the water quality committee of the Izaak Walton League and chairman of Iowa's "Save Our Streams" committee. . . . **Lee Poppen**, Wright County Attorney, was guest speaker at the June meeting of the Wright County Medical Society. Poppen spoke on the child abuse situation in Iowa. . . . **Dr. Gerald F. DiBona**, professor and vice chairman of the Department of Internal Medicine at U. of I. College of Medicine, has been awarded a Senior International Fellowship of the Fogarty International Center of the National Institute of Health. Dr. DiBona, who is also chief of medical service at the VA Hospital in Iowa City, will spend one year in renal physiology research at the Institute for Experimental Medical Research at the University of Oslo in Norway.

Dr. John C. Barker, former Davenport physician who moved to Arizona a year ago, recently returned to Iowa. He began a family practice in Eldridge in July. . . . **Dr. Wing Tai Fung** and **Dr. Chung Huang**, Harlan physicians, recently completed a three-day car-

diology fellowship sponsored by Nebraska Methodist Hospital in Omaha. . . . **Dr. Carl Hanson**, retired Waterloo pediatrician, and Mrs. Hanson were honored by the Board of Directors of the Black Hawk-Grundy Mental Health Center for their contributions to the mental health of children in the community. . . . **Dr. B. N. Shivakumar** has joined the staff at the Davenport Clinic. Dr. Shivakumar is a diplomate of the American Board of Internal Medicine and was former chief of the gastroenterology section at Veterans Administration Hospital in Des Moines. . . . **Dr. Karl A. Catlin**, medical director of the Southwest Iowa Mental Health Center in Atlantic, was elected a Life Fellow by the American Psychiatric Association at its recent convention in Chicago. . . . **Dr. Michael T. Nelson**, Mason City, was guest speaker at recent meeting of the Mason City High Twelve Club. Dr. Nelson discussed the CAT scanner recently installed at St. Joseph Mercy Hospital. . . . **Dr. Shiong Shiang Lee** joined the North Iowa Medical Center in Mason City in July. Dr. Lee is chief of the pathology department.

Dr. Som Lerdkacksharn, a pediatrician, joined **Dr. Narong Jarasviroj** in Stuart in June. Dr. Lerdkacksharn completed her pediatric residency at Cook County Hospital in Chicago and subsequently served on the staff of the Chicago Board of Health. Her husband is on the staff of the Veterans Administration Hospital in Des Moines. . . . **Dr. J. C. N. Brown**, Iowa City, has been elected president of the Iowa Psychiatric Society. Dr. Brown is a clinical assistant professor of psychiatry at the U. of I. College of Medicine and has been in private practice in Iowa City since 1970. . . . **Dr. Alan Robb** began

...in the functional bowel/irritable bowel syndrome*

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(dicyclomine hydrochloride USP)

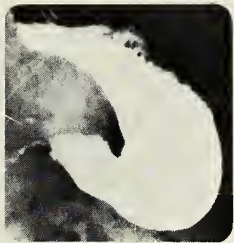
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helps control abnormal motor activity
with minimal anticholinergic side effects[†]

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Bentyl®

(dicyclomine hydrochloride USP)

Capsules, Tablets, Syrup, Injection

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences-National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSEAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg. *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

family practice in Nevada in July. A graduate of the U. of I. College of Medicine, Dr. Robb completed his family practice residency at Iowa Lutheran Hospital in Des Moines. His wife, **Dr. Wendy Buresh**, will complete her family practice residency at Iowa Lutheran Hospital in 1980 and will join her husband in practice at Nevada. . . . **Dr. Joseph F. Veverka**, Prairie City, recently was named to the board of directors of Iowa Lutheran Hospital. Dr. Veverka is the first member of the 27-member board to be elected to this position without previously serving as chief of staff. Dr. Veverka has served as director of medical education at the hospital.

Dr. Steven M. Karber began the practice of internal medicine at the clinic in Jefferson in July. Dr. Karber received the M.D. degree and completed his internal medicine residency at the U. of I. College of Medicine. . . . **Dr. Richard M. Caplan**, associate dean for Continuing Medical Education at the U. of I. College of Medicine, gave keynote addresses on "Continuing Medical Education for Tomorrow" at a University of Minnesota/Minnesota Medical Society meeting and on "Undergraduate Dermatological Education" at a workshop of the Canadian Dermatological Association. Dr. Caplan also participated in a recent workshop on "Nutrition in Cancer Education," sponsored by the National Cancer Institute. . . . **Dr. R. C. Wooters**, Polk County medical examiner, was elected a second vice president of the International Association of Coroners and Medical Examiners during the group's recent annual convention. Dr. Wooters closed his private medical practice in Des Moines in June to devote full time to his county job. . . . **Dr. Morley V. Somersall** closed his medical practice in Dumont in June and will begin postgraduate work at the State University of New York in Buffalo in July. A native of the Virgin Islands and a graduate of Howard University, Dr. Somersall located in Dumont in 1977. . . . **Dr. A. J. Havlik**, Tama physician for 45 years, underwent successful open heart surgery in Rochester, Minnesota, in June. He has resumed his medical practice.

Dr. B. Frank Vogel has rejoined the Cherokee Mental Health Institute as Director of Clinical Services, after spending three years in Mississippi in community psychiatry.

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PRESIDENT'S PRIVILEGE

Principles of medical ethics are receiving attention from various sources. The AMA House of Delegates is addressing the issue of interprofessional relations with limited licensed practitioners. AMA President Hoyt Gardner, in his inaugural address, cited ethical challenges — "the kind that pit medicine's *infinite* resourcefulness against the *finite* resources of an ever crowded world." The Texas Medical Association has taken a position prohibiting its members from giving the intravenous injection of a lethal substance in state executions. And then there is the commentary of the history of Nazi government and Nazi medicine's atrocities in "Iowa's Health" and the American College of Physicians "Forum on Medicine," pointing out not only the now quite familiar "Jewish Holocaust" but the equal number of non-Jewish "unfit" who met the same fate in the name of conserving resources for the "fit." This very day many nations are making decisions concerning the "boat people" on a similar principle.

Physicians are often criticized for their lack of cooperation with social, economic, legal and political activities related to health. It is possible their antipathy is on the same basis as their reluctance to con-

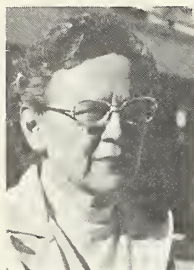
sort with unscientific practitioners in the care of patients. Physicians are somewhat conditioned to treat one patient at a time with a single-minded dedication to keeping him or her well and alive.

The medical ethic (Section 1): "Physicians should merit the confidence of patients entrusted to their care, rendering to each a full measure of service and devotion" often is in direct conflict with the expediency of many societal decisions. Currently, in the name of cost containment, review of allocation and utilization of health resources come dangerously close to interfering with the physician in rendering a full measure of service to his patient.

The surge of attention given to the tenets of medical ethics seems to reaffirm the importance of the physician's role as the advocate for his patient's care. This is likely to take on ever increasing importance as we become more and more the watchdog of patient rights. No better protector will a patient have against the vagaries of society that could declare him "unfit."

Paul M. Seebohm M.D.

Paul M. Seebohm, M.D.



QUESTIONS - ANSWERS

MARY LYONS, M.D.
DES MOINES

FRUSTRATIONS & JOYS

*Dr. Lyons is one-half of a husband-wife physician team that's practiced medicine in Des Moines for better than 25 years. Her brief responses here are to questions prompted by the reading of a review of a book written by Martin Lipp, M.D., entitled *Respectful Treatment*. It is described as a practical guide to the human side of medical care for nonpsychiatrists.*

"On those days when your . . . enthusiasm seems to flag, there are ways to rekindle the deep satisfactions that most physicians need to obtain in daily practice." How do you respond to this quote from a book review in a recent issue of AM NEWS? Do you have any such ways?

I'm sure all physicians experience days when the level of enthusiasm dips somewhat. When this occurs I try to take care of everything I can before leaving the office. Then I attempt to leave the problems and burdens of my patients at the office. My rekindling is best accomplished by going home and getting into some challenging or beautiful reading.

How would you describe the "deep satisfaction" you receive from medical practice?

The simple and obvious answer to this question, and the honest one, is that my satisfaction derives from the warm interaction and rapport

(Please turn to page 350)

QuinammTM

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication. Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:

1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

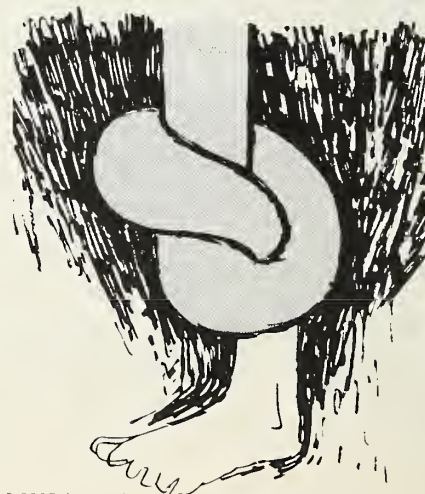
Product Information as of September, 1977
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VOX DOCS

It is said physicians have strong views and opinions. The editors of the JOURNAL want to measure, to an extent, the opinions of Iowa physicians. We plan to do so on a variety of questions and topics over the next few months. We will continue the feature for a time if there is sufficient interest and response.

This is how our *Vox Docs* feature will work. Below (in the bold type) is a statement and an inquiry. We would like your answer. Please indicate your opinion by checking the appropriate box. We have provided additionally several lines for you to tell us why you have answered as you have. If you choose simply to check one of the boxes, fine, but we would like to have your comment. If you prefer not to indicate your name, that's okay, but again we'd like to know.

Our intention next month will be to show the answers (in percentage of total) in the space to the right. You will be able to see how your response lines up.

Hereafter, in the space where you are now reading, we will place some of the comments which accompany the checked boxes. Be incisive and brief. There is no prize, but it might be interesting reading.

**IN THIS SPACE
NEXT MONTH
YOU WILL SEE
A TABULATION OF RESPONSES
TO THE INQUIRY BELOW.
YOUR PARTICIPATION
IS INVITED.**

So, those are the ground rules for our venture into opinion sampling. To summarize: (1) Check the box that reflects your opinion; (2) Add a comment as to why; (3) Clip and send the response to IMS Headquarters, and (4) Wait for the next issue to see if you are with the majority.

A Russian physician — an authority on reanimation — has been reported as saying the normal life span of humans should be about 150 years. He claims people die before they should because of "mechanical breakdowns," which are repairable. Do you agree with the 150-year idea?

☐ **SOUNDS POSSIBLE**

☐ **HIGHLY UNLIKELY**

☐ **NEXT TO IMPOSSIBLE**

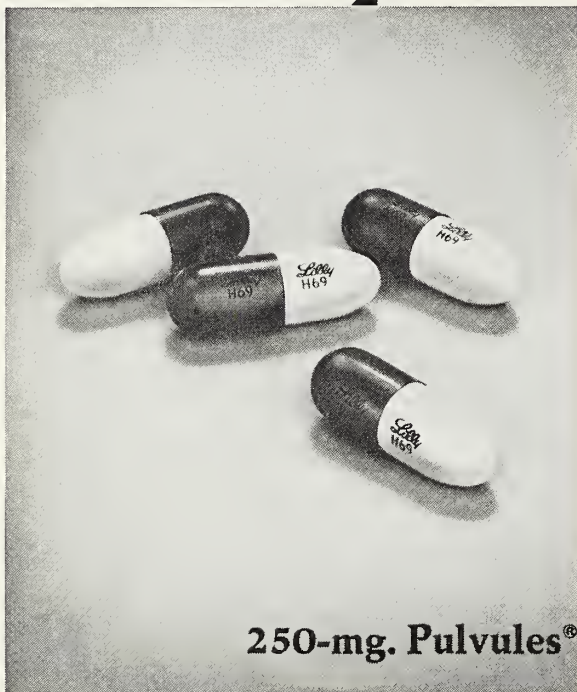
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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

CME AND THE BODHISATTVAS

With summertime comes a chance for horizon-expanding. Some of that comes with travel, some with "catch-up" and "go-forward" reading, and some with visiting of historical sites, museums and galleries. A confluence of experiences occurred today that strangely attached themselves to each other. (That seems to happen as the cerebral circuits whirl about seeking their proper storage site, much as a dog circles in the grass to prepare his resting place.)

In a major Oriental collection I saw a carved figure that appealed to me. My eye sought the identifying placard. It not only said "Bodhisattva," as so many Oriental and Indian figures are identified, but it gave a definition as well. I'd been remembering a bodhisattva as

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

SLIGHT SPRUCE UP

This September issue of the IMS JOURNAL has several innovations to mark the start of the 1979 fall season. We have changed our regular headings to one column (they were two before, for the most part). This move will allow for slightly more text material and still keep a somewhat less-than-cramped look.

We've given new designations to our

some sort of minor deity in Buddhism — mature solid-looking "people" without wings. But the placard offered a definition with a different emphasis: "Bodhisattva — a Buddhist deity who postpones enlightenment in order to assist living beings." You can see why that made me think of the physicians people talk about (I seem never to encounter them) who are so perpetually ministering to the sick that they never have time to participate in CME.

Then later today I read the article by Stross and Harlan in JAMA (241:2671), "The Dissemination of New Medical Information." They sought to learn how many family physicians and internists, representative of Michigan practitioners and attending CME courses at Ann Arbor, were aware of the important findings learned via a major cooperative clinical trial that studied photocoagulation as an important advance in treating diabetic retinopathy. The results of the photocoagulation study had first appeared 18 months earlier. Forty-six per cent of the internists knew of the study results, and 28% of the family doctors knew. But in solving two simulated patient management problems, only 33% of the doctors handled correctly the matter of referral for photocoagulation (42% of internists and 21% of family doctors). Stross and Harlan properly urge more effort be made to disseminate the results from major clinical trials.

What time lag is acceptable before at least 99% of practitioners adopt something new, once the weight of evidence becomes persuasive? If you or your patient had diabetic retinopathy, you'd certainly want the benefit of

(Please turn to page 350)

standing features for a little change of pace. For example, while he is our man (see above) only in a figurative sense, Dr. Caplan is generally regarded as Iowa's best informed physician when it comes to continuing education. We've been pleased to offer his comments regularly and hope to continue under this new banner.

Things You Should Know, About Iowa Physicians, Vox Docs and the rest — we hope you will find it all interesting and worthy of reading on a regular basis. We welcome your comments. — *The Editors*

OUR MAN ON EDUCATION

(Continued from page 349)

the latest proven advance at the *earliest possible* time. Would being too busy caring for the sick (certainly a virtuous pursuit, mind you), and thus postponing enlightenment (as a bodhisattva), be an acceptable excuse for remaining unenlightened? And if enlightenment doesn't dawn to the world on the day of first publication, what lag is tolerable? To serve patients best requires keeping up. The whole problem called "adoption of innovation" provides an immense challenge to editors, teachers, and especially to busy practitioners — one of our weightiest ethical responsibilities.

QUESTIONS — ANSWERS

(Continued from page 346)

that I enjoy with most of my patients. One quote attributed to Author Lipp is salient here: "The practice of medicine is hard enough as it is. One thing that makes it easier is finding some fun in your work. And liking the people you're taking care of adds to the fun. Sometimes it's tricky to find things to like in some patients, but it's worth the effort, not for the patient's benefit solely, but for the doctor's."

If you had it to do over, be a physician that is, would you?

I do not even have to hesitate here. My answer is unequivocally YES. The gratification has far outweighed any frustration.

What capsule advice would you give the medical student now in school?

We live in an era of depersonalization, this is a reality with which we must deal. I would advise today's students to try to establish a viable relationship with each patient, let them know that you see them as a unique person and value them for what they are.

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INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma, agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, hypertensive crises may result.

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression, changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache, rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in mid-morning. Tenuate is not recommended for use in children under 12 years of age.

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SCIENTIFIC ARTICLES

Changing Attitudes Toward Dementia

ANTONIO R. DAMASIO, M.D., and

MAURICE W. VAN ALLEN, M.D.

Iowa City, Iowa

TO MANY PHYSICIANS the diagnosis of dementia means the identification of progressive mental deterioration, accompanied by progressive motor incapacity, leading to early loss of independence, complete disability and early death. Whether dealing with so-called senile dementias, or with those with onset in the fifth or sixth decades, physicians have conceived of the underlying process as one of either natural or premature aging of the brain. As for treatment, the entrenched idea has been there is nothing to offer and a fatal course is not modifiable by therapy. The concept that dementia is a single and untreatable pathologic entity has dominated medical thinking until recently.

This concept has been changing gradually

The authors are associated with the Department of Neurology, University of Iowa Hospital and Clinics, Iowa City, Iowa. This paper emanates from the Division of Behavioral Neurology.

The opportunity should not be missed to treat those cases of dementia for which treatment is available. Physicians today can identify the various dementia syndromes and help can be given to some patients. As a result, the word dementia is losing its discouraging connotations.

however, and it is hoped it will change more radically in our community. Three factors have contributed to the modification in attitude. First, is a realization the term dementia is a merely descriptive one, which does not denote a disease entity and does not hallmark an irreversible process. Secondly, it is evident that many demential syndromes are treatable. Thirdly, is the realization, only now beginning, that dementia is not a symptom of aging, and the demential syndromes are manifestations of a complex of diseases which all adults may develop although older adults are at a greater risk.

It has become obvious the term dementia merely designates the presence of acquired impairment of intellectual and affective abilities, of sudden or insidious onset. The

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE
AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF SEPTEMBER 1979.

term does not have any neuropathologic implication whatsoever, should not be equated with a single disease, and should not be taken as a synonym of helpless fate since the clinical label does not relate to the outcome. Nor does the label refer to a uniform cluster of signs and symptoms. A wide variety of clinically distinctive demential syndromes may be individualized if close attention is paid to the mode of onset of the early signs, to their subsequent rate of development and to their interrelations, and indeed more needs to be known in this regard. The objective detection of dementia, generally made on the basis of a single observation at some point in the clinical course, does not by itself reflect the previous evolution of the syndrome and has, by itself, little predictive value. The designation *demential syndrome* should really be favored over that of *dementia*, and it should be understood there is a variety of clinical presentations and pathologic origins, and they may or may not be amenable to therapy.

TREATMENT POSSIBILITY

The second factor is the possibility of treatment. For many physicians and for the public in general treatment is never related to dementia except in a negative way. Fortunately, therapeutic prospects are improving. An increasing number of demential syndromes can be successfully ameliorated. The most common treatable syndromes are consequent to slowly growing *intracranial tumors*, involving directly or indirectly structures in the frontal and temporal lobes, particularly those which are part of the so-called limbic system, and therefore close to the control of processes of memory and affect. It is surprising how many of those tumors may produce a demential syndrome before they cause clear cut focal signs or signs of raised intracranial pressure which would immediately identify them. Naturally, these are cases in which, sooner or later, the true etiology will be recognized. But the early detection of a tumoral cause may turn a bad prognosis into a rather acceptable one, by allowing the neurosurgeon to act at an optimal stage. A similar statement could be made about *chronic subdural hematomas* whose only clinical manifestation may be of a quietly progressive demential syndrome.

Another surgically treatable demential syn-

drome is that associated with *low pressure hydrocephalus*. First described in the early sixties, this condition has received considerable attention in the past 10 years and probably has, singlehandedly, contributed more to the attitudinal change towards dementia than any single factor. The pathogenesis of the syndrome is not well understood, but the signs are distinctive and the presence of gait apraxia, sphincter abnormalities, rigidity and bradikinesia, together with the subacute onset of intellectual deterioration should suggest it. However, several cases have been described which presented in a form indistinguishable from Alzheimer's disease. At any rate, surgical approach, with ventricular shunting, brings improvement in many cases. Modern management includes extensive neuroradiological evaluation and monitoring of intracranial pressure. Precise criteria for selection of surgical candidates are now being developed.

Prime examples of treatable dementias are provided by a number of *metabolic disorders* which may produce mental deterioration before or in the absence of clear signs of non-neurological disease. Cases of endocrinopathy, particularly hypothyroidism and hyperparathyroidism may be accompanied by insidious dementia. The same is true of Cushing's disease though to a much lesser degree. Unless proper care is taken to screen for those primary disorders, the true cause will be missed. The same may be said of subtle cases of dementia with vitamin deficiency, particularly B₁₂. This syndrome may appear in the absence of the dramatic and less ambiguous myelopathy.

Potentially correctable hematologic disorders (such as polycythemia, for instance), and cardiovascular disorders (e.g., maintained low cardiac output syndrome), are also good examples of treatable dementia and we will only mention the matter of "multi-infarct dementia" whose worsening course may be stalled by appropriate management and, above all, prevented by adequate treatment of several cardiovascular disorders and diabetes.

FURTHER TREATABLE DISORDERS

Subacute or chronic infection is another remediable cause of dementia. Syphilis is in fact the model of the treatable demential syndrome. We are referring here to the tertiary

meningovascular type of syphilitic infection associated with a vasculitis as well as the paretic type. Some patients may go back to a productive life after an appropriate treatment, and this diagnostic possibility should not be overlooked even if it may seem remote in these times. Insidious fungal infection and brucellosis may also produce a demential syndrome.

Another important instance of treatable dementia is severe *depressive illness*, occasionally described as depressive pseudodementia. The interaction of depression and advanced age may produce a picture of motor inhibition, affective bluntness, and cognitive and verbal impairments, which may be difficult to distinguish from idiopathic cases unless proper neuropsychologic assessment is carried out and due consideration is given to the circumstances in which the disease started. This is a frequent and often missed condition, which is tragic since the response to antidepressant medication is excellent.

In an almost interminable list, the syndromes secondary to chronic administration of certain drugs should be singled out, particularly the anticholinergics (for instance, the commonly used Artane®), which are often responsible for confusional episodes in the elderly, and which may, in certain instances, give rise to a persisting picture of mental impairment.

DIAGNOSTIC INVOLVEMENT

This is not the place to discuss the diagnostic approach to the demential syndromes, but let it be emphasized, for the time being, the only way to avoid missing a treatable case is to think of all the reasonable causes and exclude them one by one. There is no short cut, and this is certainly a situation in which a little diagnostic extravagance pays good dividends. This means the routine workup of the demented patient should include extensive blood chemistry studies, EEG, radionuclide scanning, (a) specialized neuropsychological assessment and (b) computerized tomography of the head, and, if appropriate, CSF studies.

There is no circumstance in which a patient should be simply dismissed as demented or suffering from a degenerative process without an attempt to rule out a treatable disorder. Naturally, an experienced clinician will be correct in his diagnostic impression in most cases,

but even the most honored clinical criteria may fail him. For instance, the time course of the syndrome is, in our view, a good indicator of the nature of the underlying pathologic picture. The syndromes of insidious onset and slow progression are more frequently degenerative, while those of subacute onset and rather rapid worsening tend to be secondary to some correctable neurological or non-neurological process. However, this vague rule is riddled with exceptions. The dementias of vitamin or endocrine disorders may be insidious, slow, chronic and yet very treatable. On the other hand, some of the subacute dementia syndromes, like that of Creutzfeldt-Jacob for instance, may be relatively acute and cannot be helped by any treatment.

DEMENTIAL SYNDROME

The third factor which is changing our attitude towards dementia is the awareness that the demential syndromes result from a wide variety of disease processes which are possibly different from the process of aging of the nervous system. Dementia is not to be mistaken with aging of the nervous system, although it is clear that among the unknown factors governing its appearance, some genetic and some environmental, age is important and the risks of acquiring the condition increase after the middle of the seventh decade. Considerable evidence now suggests that the so-called presenile and senile dementias are but one disease, which we can call Alzheimer's and whose major neuropathologic features include a general atrophy of the brain, a loss of neurons and the presence of neurofibrillary tangles, granulovacuolar changes and senile plaques. In the view of modern researchers, this is a disease entity proper, one in which the intensity of the histological picture correlates fairly well with the behavioral devastation seen by the clinician (Blessed, Tomlinson and Roth, 1968; Fisher, 1968; Tomlinson, Blessed and Roth, 1970).

We must distinguish the intellectual decay of Alzheimer's disease from the benign memory loss of the aged. It is true that old people have anomic difficulties, but don't we all when we are tired? And it is well known that old people develop a weaker and shorter stepped gait and tremulousness, but has that got anything to do

(Please turn to page 355)

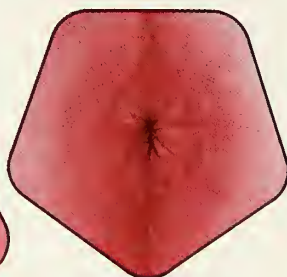
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Care should be taken when using the corticosteroid hydrocortisone acetate in children and infants. Anusol-HC is not for ophthalmic use.

Dosage and Administration: Anusol-HC Suppositories—Adults: Remove foil wrapper and insert suppository into the anus. One suppository in the morning

and one at bedtime, for 3 to 6 days or until inflammation subsides. Then maintain patient comfort with regular Anusol Suppositories.

Anusol-HC Cream—Adults: After gentle bathing and drying of the anal area, remove tube cap and apply to the exterior surface and gently rub in. For internal use, attach the plastic applicator and insert into the anus by applying gentle continuous pressure. Then squeeze the tube to deliver medication. Cream should be applied 3 or 4 times a day for 3 to 6 days until inflammation subsides. Then maintain patient comfort with regular Anusol Ointment.

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(Continued from page 353)

with the major motor signs of Alzheimer's disease?

ABSENCE OF INFORMATION

These ambiguities have very possibly been responsible for a lack of medical interest in the condition and, consequently, an almost complete ignorance of its social impact. It is surprising there is no good information on the incidence and prevalence of Alzheimer's in the United States. The same is true of most of the rest of the world, the exceptions being Great Britain and the Scandinavian countries, where some epidemiological research has been undertaken (Bremer, 1951; Essen-Møller, 1956; Nielsen, 1963; Kay, Beamish, Roth, 1964). If those studies are correct, the overall prevalence of severe Alzheimer's in the population is 4%, and for mild Alzheimer's is 11%. But in the population above 65 years of age, a group which is increasing constantly due to improvement in general health care, the incidence rises to staggering values as discussed by Tomlinson, Blessed and Roth (1970). This means that if this data were transferred to the USA, the present day prevalence and incidence of dementia would produce an amazing figure (Katzman, 1976), which would not include other dementias on a degenerative basis, like those accompanying Huntington's disease, the cerebellar degenerations and some extrapyramidal syndromes. The figures also would not include another major cause of "non-treatable" dementia, multiple infarction of the CNS, related to cardiovascular disorders, particularly disease of the neck vessels, and systemic hypertension.

The human and social costs of Alzheimer's disease are difficult to calculate. The fact that Alzheimer's is a disease which kills or helps to kill its carrier further increases the toll. Here, too, our knowledge of this epidemiologic point is sparse, but there is little doubt that the survival of a patient with Alzheimer's is significantly lower than that of a nonaffected subject of the same age. Kay (1962) points out the average survival of a patient with Alzheimer's is 2.6

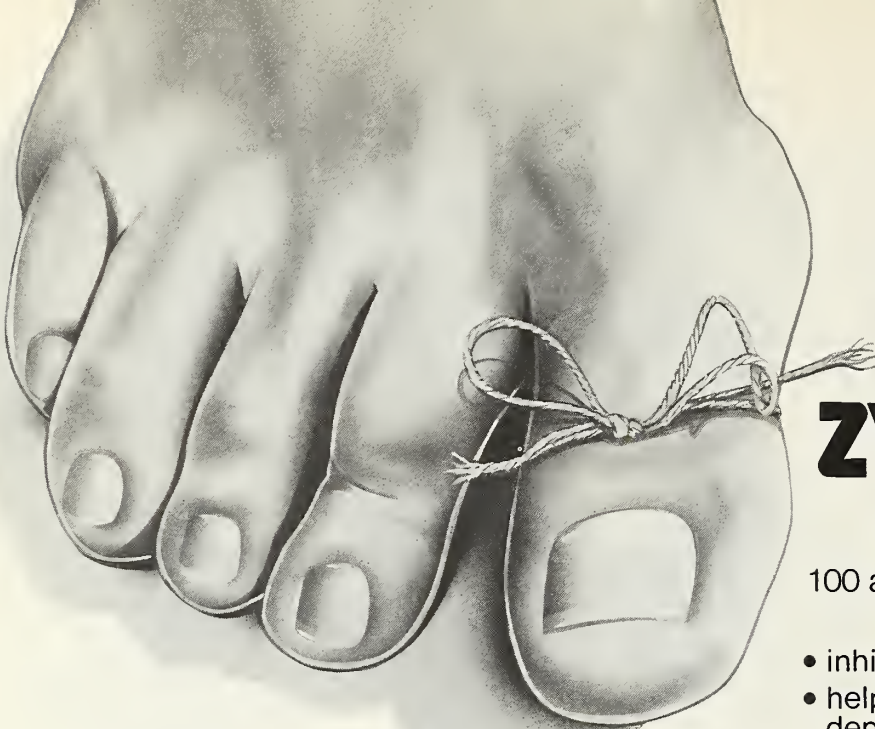
for males and 2.3 for females. The average survival of the non-affected population of comparable age is, respectively, 8.7 and 10.9 years. Even the more optimistic studies, such as that of Wang and Whanger (1971), agree that life expectancy after the onset of dementia is reduced by at least half. Whether by itself, or by sponsoring the appearance of associated conditions, such as pulmonary infection or embolism, Alzheimer's disease is a killer.

SUMMARY

To be sure, the solution of the problem of the degenerative dementias will come as the result of a major investigative effort. Obviously, the prevention or treatment of these diseases is a long way from us. As an immediate and feasible goal, however, we should learn more about their natural history and distribution. Another immediate goal is the individualization of significant syndromes in the hope they will be clearly associated with certain neuropathologic conditions and therefore make way for more effective, less expensive diagnosis. But, most important of the immediate aims is that we should not miss the opportunity of treating those cases which may indeed be treated. The fact that all of us can, today, identify and help some of the patients should give us some optimism. At long last the word dementia is losing its discouraging connotations.

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A reminder

ZYLOPRIM[®]

(allopurinol)

100 and 300 mg scored Tablets

- inhibits uric acid formation
- helps prevent urate crystal depositions in synovia
- reduces risk of uric acid lithiasis

INDICATIONS AND USE: This is not an innocuous drug and strict attention should be given to the indications for its use. Pending further investigation, its use in other hyperuricemic states is not indicated at this time.

Zyloprim[®] (allopurinol) is intended for:

1. treatment of gout, either primary, or secondary to the hyperuricemia associated with blood dyscrasias and their therapy;
2. treatment of primary or secondary uric acid nephropathy, with or without accompanying symptoms of gout;
3. treatment of patients with recurrent uric acid stone formation;
4. prophylactic treatment to prevent tissue urate deposition, renal calculi, or uric acid nephropathy in patients with leukemias, lymphomas and malignancies who are receiving cancer chemotherapy with its resultant elevating effect on serum uric acid levels.

CONTRAINDICATIONS: Use in children with the exception of those with hyperuricemia secondary to malignancy. The drug should not be employed in nursing mothers.

Patients who have developed a severe reaction to Zyloprim should not be restarted on the drug.

WARNINGS: ZYLOPRIM SHOULD BE DISCONTINUED AT THE FIRST APPEARANCE OF SKIN RASH OR ANY SIGN OF ADVERSE REACTION. In some instances a skin rash may be followed by more severe hypersensitivity reactions such as exfoliative, urticarial and purpuric lesions as well as Stevens-Johnson syndrome (erythema multiforme) and very rarely a generalized vasculitis which may lead to irreversible hepatotoxicity and death.

A few cases of reversible clinical hepatotoxicity have been noted and in some patients asymptomatic rises in serum alkaline phosphatase or serum transaminase have been observed. Accordingly, periodic liver function tests should be performed during the early stages of therapy particularly in patients with pre-existing liver disease. Patients should be alerted to the need for due precautions when engaging in activities where alertness is mandatory.

Nevertheless, iron salts should not be given simultaneously with Zyloprim. This drug should not be administered to immediate relatives of patients with idiopathic hemochromatosis.

In patients receiving Purinethol[®] (mercaptopurine) or Imuran[®] (azathioprine), the concomitant administration of 300-600 mg of Zyloprim per day will require a reduction in dose to approximately one-third to one-fourth of the usual dose of mercaptopurine or azathioprine. Subsequent adjustment of doses of Purinethol or Imuran should be made on the basis of therapeutic response and any toxic effects.

Usage in Pregnancy and Women of Childbearing Age: Zyloprim[®] (allopurinol) should be used in pregnant women or women of childbearing age only if the potential benefits to the patient are weighed against the possible risk to the fetus.

PRECAUTIONS: Some investigators have reported an increase in acute attacks of gout during the early stages of allopurinol administration, even when normal or sub-normal serum uric acid levels have been attained.

It has been reported that allopurinol prolongs the half-life of the anticoagulant, dicumarol. This interaction should be kept in mind when allopurinol is given to patients already on anticoagulant therapy, and the coagulation time should be reassessed.

A fluid intake sufficient to yield a daily urinary output of at least 2 liters and the maintenance of a neutral or, preferably, slightly alkaline urine are desirable to (1) avoid the theoretic possibility of formation of xanthine calculi under the influence of Zyloprim therapy and (2) help prevent renal precipitation of urates in patients receiving concomitant uricosuric agents.

Patients with impaired renal function require less drug and should be carefully observed during the early stages of Zyloprim administration and the drug withdrawn if increased abnormalities in renal function appear.

In patients with severely impaired renal function, or decreased urate clearance, the half-life of oxipurinol in the plasma is greatly prolonged. Therefore, a dose of 100 mg per day or 300 mg twice a week, or perhaps less, may be sufficient to maintain adequate xanthine oxidase inhibition to reduce serum urate levels. Such patients should be treated with the lowest effective dose, in order to minimize side effects.

Mild reticulocytosis has appeared in some patients.

As with all new agents, periodic determination of liver and kidney function and complete blood counts should be performed especially during the first few months of therapy.

ADVERSE REACTIONS:

Dermatologic: Because in some instances skin rash has been followed by severe hypersensitivity reactions, it is recommended that therapy be discontinued at the first sign of rash or other adverse reaction (see WARNINGS). Skin rash, usually maculopapular, is the adverse reaction most commonly reported.

Exfoliative, urticarial and purpuric lesions, Stevens-Johnson syndrome (erythema multiforme) and toxic epidermal necrolysis have also been reported.

A few cases of alopecia with and without accompanying dermatitis have been reported.

In some patients with a rash, restarting Zyloprim (allopurinol) therapy at lower doses has been accomplished without untoward incident.

Gastrointestinal: Nausea, vomiting, diarrhea, and intermittent abdominal pain have been reported.

Vascular: There have been rare instances of a generalized hypersensitivity vasculitis or necrotizing angitis which have led to irreversible hepatotoxicity and death.

Hematopoietic: Agranulocytosis, anemia, aplastic anemia, bone marrow depression, leukopenia, pancytopenia and thrombocytopenia have been reported in patients, most of whom received concomitant drugs with potential for causing these reactions. Zyloprim[®] (allopurinol) has been neither implicated nor excluded as a cause of these reactions.

Neurologic: There have been a few reports of peripheral neuritis occurring while patients were taking Zyloprim. Drowsiness has also been reported in a few patients.

Ophthalmic: There have been a few reports of cataracts found in patients receiving Zyloprim. It is not known if the cataracts predated the Zyloprim therapy. "Toxic" cataracts were reported in one patient who also received an anti-inflammatory agent; again, the time of onset is unknown. In a group of patients followed by Gutman and Yu for up to five years on Zyloprim therapy, no evidence of ophthalmologic effect attributable to Zyloprim was reported.

Drug Idiosyncrasy: Symptoms suggestive of drug idiosyncrasy have been reported in a few patients. This was characterized by fever, chills, leukopenia or leukocytosis, eosinophilia, arthralgias, skin rash, pruritus, nausea and vomiting.

OVERDOSAGE: Massive overdosing, or acute poisoning, by Zyloprim has not been reported.

HOW SUPPLIED: 100 mg (white) scored tablets, bottles of 100 and 1000; 300 mg (peach) scored tablets, bottles of 30, 100 and 500. Unit dose packs for each strength also available.

Complete information available from your local B. W. Co. Representative or from Professional Services Department PML.

U.S. Patent No. 3,624,205 (Use Patent)



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Bizarre Leiomyoblastoma of Ileum: Report of Case with Electron Microscopy

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Des Moines, Iowa

The leiomyoblastoma is a rare tumor which has been reported to occur in any level of the gastrointestinal tract. Its histogenesis is not known. The electron microscope is used here to confirm the diagnosis in this case.

CASE REPORT

A 74-year-old Caucasian female was admitted to Mercy Hospital in Des Moines with a history of sudden onset of cramping pain in the upper abdomen. The discomfort radiated to the shoulders and both arms 4 weeks prior to her admission. She had mild, well-controlled hypertension. Physical examination was not remarkable except for a large cystic pelvic tumor reaching up to the umbilicus. It was freely moveable and appeared to have no connection with the uterus. On pelvic examination there was a 4 degree uterine prolapse with rectocystocele. The lab and X-ray findings were non-significant. With the pre-operative diagnosis of an ovarian cyst, an exploratory laparotomy was performed which revealed a large cystic tumor attached to a loop of the ileum by a small pedicle. The cystic tumor was resected with the involved segment of the ileum. No abnormalities were found in the pelvic organs. The post-operative course was uneventful.

PATHOLOGY

On opening the segment of the ileum there was a polypoid tumor, 2 by 2 by 1.5 cm, pro-

THE TERM "bizarre leiomyoblastoma" was suggested by Stout in 1962 to designate a series of 69 gastric tumors having bizarre atypical histological appearance for leiomyomas, but still having certain common features for smooth muscle tumors.¹ Earlier, Martin described⁶ examples of similar tumors.²

Although Martin and Stout both postulated that they represent smooth muscle tumors, the histogenesis of this tumor is still not well understood.

Recently, electron microscope studies³⁻⁵ of a few cases of bizarre leiomyoblastomas revealed some ultrastructural resemblance to smooth muscle cells lending support to the concept of smooth muscle origin.

This paper concerns a 74-year-old female with a large abdominal tumor arising from the ileum which turned out to be a leiomyoblastoma on light and electron microscopic studies.

The authors are associated with the departments of pathology, family practice and gynecology at Mercy Hospital in Des Moines, Iowa.

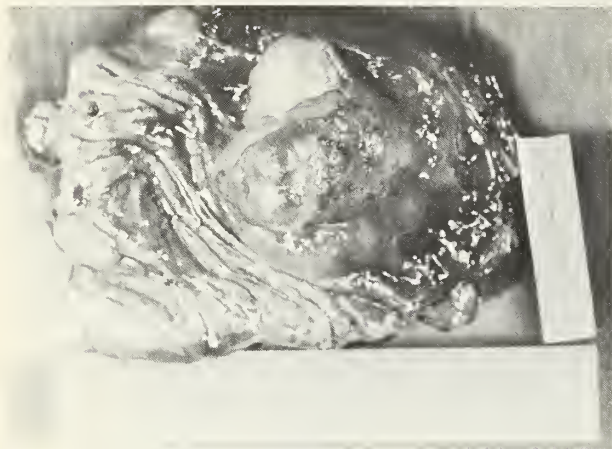


Figure 1. The resected segment of the ileum showing a protruding tumor with mucosal ulceration.

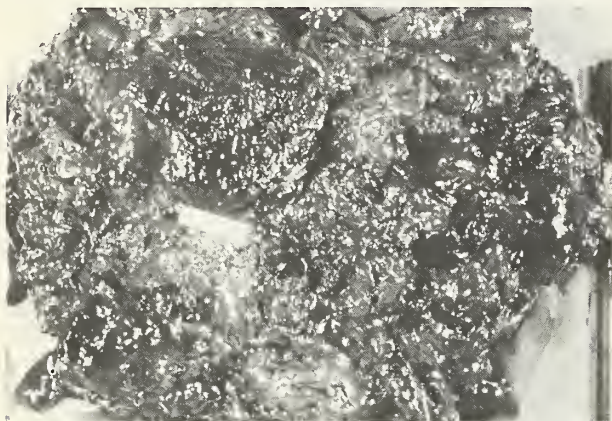


Figure 2. The cut surface of the serosal cystic tumor showing hemorrhagic contents. This was connected to the luminal tumor (Fig. 1) by a narrow pedicle.

truding into the lumen which extended out through the muscular wall by a narrow neck and continued to the large cystic serosal tumor, measuring 17 by 17 by 10 cm. The mucosa over the luminal tumor was ulcerated (Figure 1). On cut sectioning, the tumor was grayish with fairly well circumscribed borders to the ileal musculature, except for the serosal side where the intramural grayish tumor merged into a large hemorrhagic cystic mass (Figure 2). A narrow rim of tumor tissue was identifiable along the fibrous cystic wall.

The tumor samples were fixed in 10% buffered neutral formalin and paraffin sections were stained with hematoxylin-eosin, Masson's trichrome, phosphotungstic acid, hematoxylin, PAS, Wilder's reticulum stains and Bodian's nerve fibre stain. For electron microscopy, small blocks of formalin-fixed tumor tissue were refixed in buffered glutar-

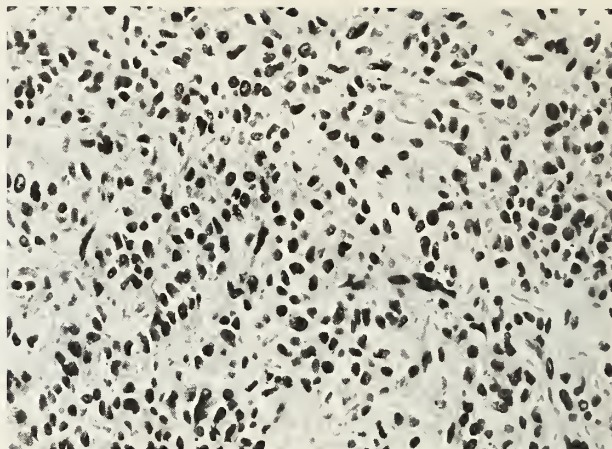


Figure 3. Tumor cells were epithelioid in appearance and attempted to form nests in most areas. Hematoxylin-eosin, $\times 450$.

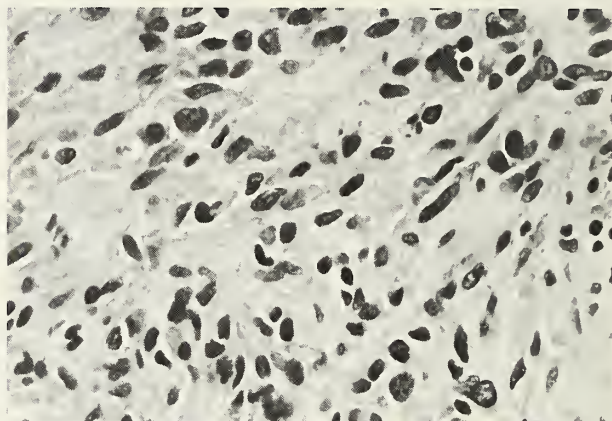


Figure 4. In areas, the tumor cells were slightly spindle and arranged in a fascicular pattern. Hematoxylin-eosin $\times 1,000$.

aldehyde and post-fixed with osmic acid. Ultra-thin sections of plastic-embedded material stained with uranyl acetate and lead citrate were examined under a Philip's 301 Electron Microscope (by the courtesy of Ferenc Gyorky, M.D., Professor of Pathology, Baylor College of Medicine and Chief, Laboratory Service, V.A. Hospital, Houston, Texas).

Microscopically, the tumor was composed of oval to polygonal cells having round nuclei with slight variation in size and differing amounts of eosinophilic cytoplasm. The tumor had abundant loose amorphous vascular stroma and the tumor cells appeared epithelioid with abortive attempts to form cell clusters (Figure 3). In other areas, the tumor cells were spindle in shape and exhibited a fascicular pattern suggesting their smooth muscle origin (Figure 4). The fascicular pattern was conspicuous at the periphery of the tumor

where the tumor growth appeared to be pushing the neighboring normal muscle coat of the ileum. The tumor had infiltrative features at the periphery without any recognizable capsule. The center of the tumor was necrotic and hemorrhagic and the serosal cystic areas represented a hematomatous sac with a thin rim of viable tumor tissue at the periphery forming the cystic wall.

There were rare mitoses and the mitotic rate was less than one in 50 high power field. Results on histochemical stainings suggested differential diagnosis of bizarre leiomyoblastoma, fibrohistiocytoma, or neurogenic tumors.

Electron microscopically, the tumor cells had varying sized nuclei with slightly undulating nuclear envelope, peripherally dispersed nuclear chromatin and small distinct nucleolus. The cytoplasm was abundant and contained profiles of rough-surfaced endoplasmic reticulum, sparse mitochondria, Golgi apparatus and scattered polysomes (Figure 5). There were occasional fatty vacuoles and small membrane-bound dense bodies. The prominent cytoplasmic features were the presence of whirly microfilamentous tangles (Figure 6) consisting of stacks of microfilaments measuring 60 Å in thickness. In addition, there were irregular areas of increased electron density in the cytoplasm associated with irregularly arranged microfilaments at the periphery of the cytoplasm. The cytoplasmic borders were, in general, not well preserved. However, occasional symmetric membrane thickenings were suggestive of desmosomal attachment between cells. There were varying amounts of intercellular spaces filled with flocculant material containing cross sections of cytoplasmic extensions and occasional collagen fibers with typical 640 Å periodicity. The tumor cells were interspersed by frequent venules having prominent pericytes enmeshed in basal lamina material. In areas, the basal lamina extended to surround the tumor cells and in such areas the tumor cells were closely intimated with venular pericytes suggestive of pericytic origination of the tumor cells. There was no evidence of glial fibers. There were frequent lymphocytic cells, particularly in the perivascular areas.

COMMENT

The ultrastructural features of the tumor presented herein are similar to those of bizarre

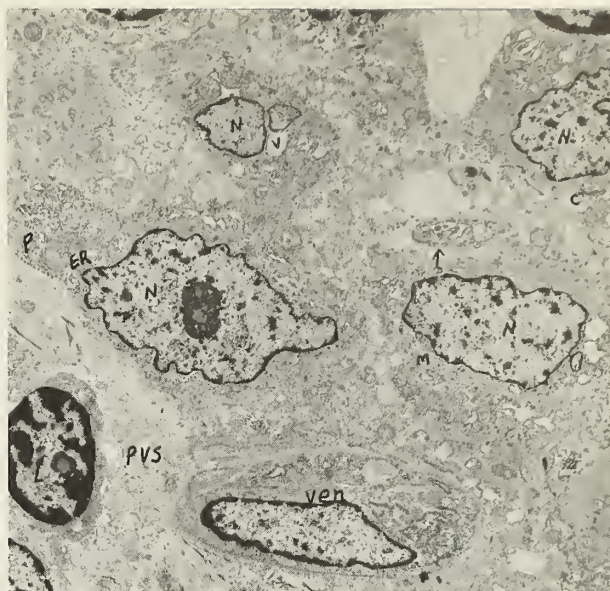


Figure 5. The tumor cells had irregular shaped nuclei (N) with undulating and invaginating nuclear envelopes. The cytoplasm was abundant containing mitochondria (M), profiles of endoplasmic reticulum (ER), polysomes (P) and vesicles (V). Note increased cytoplasmic densities in the cytoplasmic extension in the intercellular space (arrow). The tumor cells were arranged around the venules (VEN). L: Lymphocyte; C: Collagen; PVS: Perivascular space. $\times 6,250$.

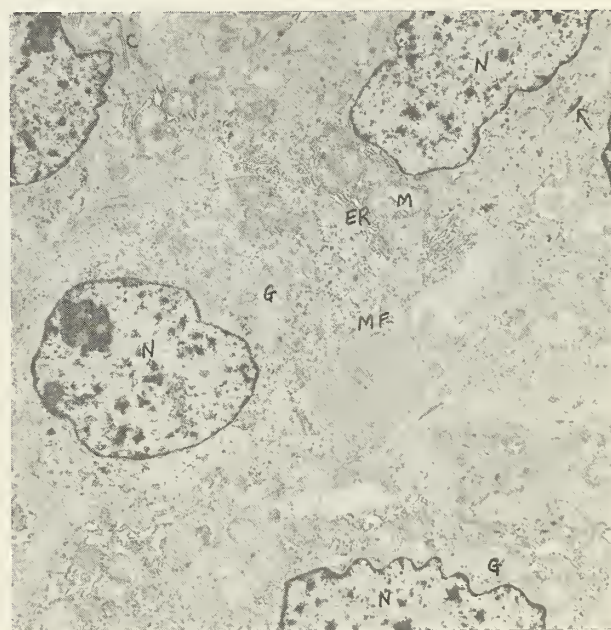


Figure 6. Another prominent feature was the whirly tangles of microfilaments (MF). G: Golgi apparatus. $\times 8,500$.

leiomyoblastoma reported by Salazar and Totten⁴ justifying the diagnosis of a leiomyoblastoma. The light microscopic features were only suggestive of the diagnosis and electron microscopy revealed diagnostic ultrastructural

features reasonably excluding the other possibilities.

By virtue of its high resolution capability, the electron microscope has been a favorite research tool in the study of biological material and disease process in the last several decades, but it is only recently that the usefulness and practicality of electron microscopy in the routine surgical pathology laboratory has been realized.⁶⁻⁸ It has been claimed that in 4 to 8% of biopsies studied, a better diagnosis is obtained by ultrastructural studies.

The leiomyoblastoma is a rare tumor which has been reported to occur in any level throughout the gastrointestinal tract,^{9, 10} mesentery,¹¹ retroperitoneum,¹² and uterus.^{9, 13} The majority of these tumors follow a clinically benign course and only a few have been associated with malignant behavior. Stout¹ and others¹⁴ state there is no dependable histologic criterion to determine the eventual clinical behavior, although high mitotic rate is usually associated with malignant course. In our case, mitotic rate was low, less than one in 50 high power field, suggesting its benignity; however, the follow up period is too short to conclude, since some of the metastasizing leiomyoblastomas had low mitotic activity.¹⁵

The histogenesis of leiomyoblastoma is not known, although their smooth muscle nature has been suggested.¹ There have been a few electron microscopic studies including ours which demonstrated certain ultrastructural features found in smooth muscle cells lending further support to the suggestion.^{4, 5}

However, there seemed to be much morphologic dissimilarities between the tumor cells in the leiomyoblastomas and normal

smooth muscle cells¹⁶ and common benign smooth muscle tumors.^{17, 18} This apparent morphologic departure from the typical smooth muscle cells, considered with the fact that the majority of leiomyoblastomas follow a benign clinical course and lack of histologic and cytologic evidence of anaplasia which usually correlates with the well differentiated nature of a tumor, suggests a possibility that "bizarre leiomyoblastomas" may represent tumors deriving from an altered or modified smooth muscle cell, not from smooth muscle cells, *per se*.

Salazar and Totten observed an intimate relationship of tumor cells to blood vessels and in particular the tumor cells were in direct contact with pericytes. The basal lamina encasing the venular pericytes were, in areas, open and shared by the pericytes and tumor cells, suggestive of the tumor cells emanating from the pericytes. Similar features were found in our own case. These morphologic observations make it attractive to conclude that the bizarre leiomyoblastomas originate from the pericytes which some investigators regard as modified smooth muscle cells or primitive multipotent cells with few ultrastructural resemblance to smooth muscle cells.¹⁹ This may explain the fact that tumor cells in so-called bizarre leiomyoblastomas exhibit only subtle resemblance to smooth muscle cells. However, this observation was made in a small number of cases and further studies in a larger series of cases are indicated.

REFERENCES

The references noted with this article are available on request either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

IMS COMMENTS ON PRIVACY

The Iowa Medical Society presented testimony in August before the Iowa Citizens Privacy Task Force. This multi-disciplinary group of Iowans has been constituted by statutory action to explore the important questions of privacy and confidentiality. The TF will report its recommendation to the 1980 Iowa General

Assembly. The August statement was made by Donald C. Young, M.D., chairman of the IMS Legislative Committee.

Society concern was expressed over the potential for misuse of confidential health care information in our highly technologic and computerized time. It was suggested that reasonable restrictions be placed on the use and further distribution of such confidential information by third parties.

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COMMENTING EDITORIALY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

HOW TIMES CHANGE

The late summer weeks are often filled with preparation for college migration. Ahead lies a collegiate experience that will change the lives of many. Most of us remember the transition, and we now perhaps are viewing the same experience with our own children. The collegiate preparations may be similar to ours, but changes in life style have made the migration a major undertaking.

In 1940 I left my home to attend a large university. All my needed possessions were carried in one suitcase. A few additional essentials had to be purchased after arrival. How different the scene is now after all these years.

My first daughter left for college about 14 years ago. I thought then there was no more one person could transfer for daily living. Now, however, another daughter is preparing for the fall exodus. I wonder if a moving van will be needed. Clothing, shoes, bedding, pillows, high-fi units, typewriter, iron, popcorn popper, more shoes, records, and items too numerous to mention are needed for her experience away from home.

MONUMENT TO MEDICAL HISTORY

The Auxiliary of the Polk County Medical Society has undertaken a project to preserve the medical heritage of the 1870's and 1880's. A six-block pioneer town is being established at

Such a change in preparations speaks to our life patterns today — patterns based on material possessions to provide comfort and enjoyment.

The material gains of our society, through technologic advancements and social affluence, have given our lives pleasures and conveniences. Our homes are resplendent with electrically activated gadgets and furnishings; our automobiles have become large and powerful; our lives have been enriched by material gains. Our children have possessions we never dreamed could exist. Consequently, they want the luxuries and conveniences to which they have become accustomed. Our world is dependent on plastics, electricity, and computers. Yet we now face the grim fact that the energy needed for these many accepted wonders is dwindling away. (Perhaps "dwindling" is the wrong word; some would say it is being "frittered" away.)

Some of our pleasures are dependent on the sources of energy which are in short supply, so we must learn to conserve. Recently I saw a motto which stated, "Dare to conquer the rapids of life." We are at that point. We have had smooth sailing the past decade or two. Now we have come to rough waters, and we must conquer them with a steadfast determination to come through unscathed, yet with pride in accomplishment and joy in achievement. Our conservation of energies can be accomplished by abolishing waste in our hospitals as well as in our homes and offices. Cost containment programs are catching-on, and have proved successful in numerous areas. We may have to do with fewer pleasures, and fewer or smaller possessions, but life will be just as full and satisfying. Our personal lives, and the welfare of our patients, need not suffer ill effects.

I'd like to convince my daughter she does not need all those things at college, but I'm sure her desires will prevail. — M.E.A.

the Living History Farms near Des Moines, and a physician's office will be part of that restoration. There will also be a veterinarian's office, a livery stable, a general store, in addition to the Victorian mansion which stands as the centerpiece for the entire project.

The Living History Farms was established in

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COMMENTING EDITORIALY

(Continued from page 362)

1970. It has become a popular attraction in the interval, giving visitors a good look at past rural life in Iowa. Last year over 135,000 persons saw the daily routine of farming and the domestic life associated with it. Actually, there are three farms situated on 700 acres west of Des Moines. Authentic farm practices and daily living situations, as experienced in the 1840's, the 1870's, and the early 1900's, can be viewed and shared. Each summer a day camp provides children the opportunity to become involved in these life styles.

Martin Flynn, a railroad magnet, completed the beautiful Victorian mansion in 1870, a memorial to wealth of the times. In 1915 the estate was purchased by the State of Iowa and used as a prison farm until 1965. For several years the fate of the property remained in limbo until the concept of the Living History Farms reached fruition in 1970. Endowments by many large businesses, private donors, as well as some federal grants, have made the Farms a viable, private, nonprofit, historical and educational foundation.

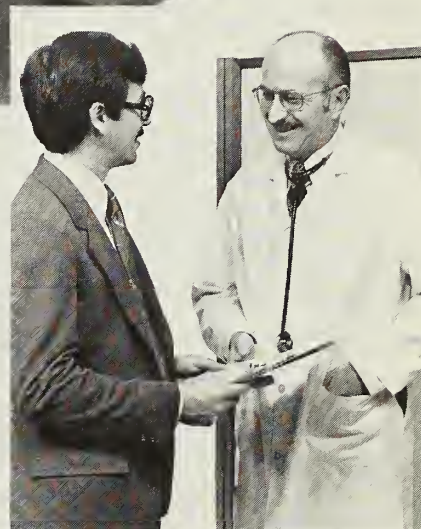
It is to this historical enterprise that the Polk Medical Auxiliary wishes to add a medical office building. It will be part of the 1870 Walnut Hill community.

The project involves moving brick-by-brick a former physician's office from Polk City. The office was built by Dr. Robert A. Armstrong, who began his life-long practice in Polk City in 1857. After the office has been moved and reconstructed it will serve as a repository for the furnishings and instruments of the time. Funds to accomplish the project are being sought from all physicians in the state. The Auxiliary wishes support for the effort to come entirely from the medical profession. It is desired and planned for the project to be ready for public viewing in two years.

The Historical Committee of the Iowa Medical Society has added its endorsement and encouragement to this notable project. Donations to the unique and worthy cause will help preserve the heritage of Iowa medicine. They are tax deductible. Gifts of medical instruments of the 1870's will be sought as well. Persons interested may contact the JOURNAL for further information. — M.E.A.



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STATE DEPARTMENT/ PUBLIC HEALTH

NEONATAL NUTRITION IN IOWA

Because a woman's nutritional status prior to and during pregnancy has profound effects on herself and her baby, a program was developed by the director of the Iowa Statewide Perinatal Program with June Claiborn, state maternal and child health nutrition consultant. The nutrition outreach program is developed for the special needs of babies in neonatal intensive care nurseries and is to be carried out by Level II hospital dietitians. Doctors Samuel Fomon and Ekhard Ziegler from the Division of Nutrition and Metabolism, University of Iowa Hospitals and Clinics, have contributed greatly to the training program.

In Iowa, as in other parts of the United States, the incidence of small babies is greatest in the mother under age 19, the mother over age 35, the mother who is economically deprived, and the mother who has frequent pregnancies. Despite our ability to identify high risk mothers, these mothers produce 60% of the high risk infants.

Recent studies indicate the majority of these survivors lead long and productive lives. This can be accounted for by the advances in technology and the cooperative interaction to regionalize the delivery of perinatal care. The small infant must overcome a multitude of complex problems to achieve this outcome. Although nutrition of the high risk infant has received much attention, and there are a number of excellent clinical studies in the literature, the nutritional requirements of the low birth-weight infant have evaded precise definition. This can be explained by the complexity of the problem and the difficulties which are encountered in design and execution of nu-

tritional studies of high risk infants. More specifically, the nutritional requirements of this group of patients appears to depend on gestational age and weight of the infant. In addition, problems associated with high risk infants, such as idiopathic respiratory distress syndrome, sepsis, and PDA drastically compromise and complicate the provision of adequate nutrition.

In an effort to start the high risk infant nutrition program, a two-day workshop was held at the University of Iowa Hospitals and Clinics January 18 and 19, 1979. The workshop was designed to provide basic principles of nutritional requirements of the newborn. Five of Iowa's Level II hospitals were represented. These were Iowa Methodist Medical Center, Des Moines; St. Luke's Medical Center, Cedar Rapids; St. Francis Hospital, Waterloo; Mercy Medical Center, Dubuque; and St. Luke's Medical Center, Sioux City. Since that time, all but one hospital have identified a dietitian on their staff or recruited an additional person to monitor the nutritional status of the infants in their intensive care nurseries.

The training program for these dietitians has been individualized as for frequency of encounters. However, the curriculum includes indepth studies of the following areas:

1. Review of the nutritional requirements of the full term infant;
2. Estimated requirements and advisable intakes of the low birth-weight infant;
3. Modes of feeding the high risk infant;
4. Monitoring nutritional status of the high risk infant; and
5. Basic neonatology.

It is the goal of the program that each dietitian who has completed the program will be able to assist the physician in implementing sound nutritional practices. She will accomplish this by monitoring the feeding regimen of the neonate with particular attention given to the caloric intake, weight gain or loss, and fluid intake in relation to the patient's maturity and/or disease. The effectiveness of the nutrition intervention will depend on the ability to assess and identify any potentially serious nutritional problems and develop remedial plans. In addition to evaluating nutritional status and outcome, the neonatal dietitian will provide the family with the knowledge and special guidance it may require for long-term management of the infant.

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(dicyclomine hydrochloride USP)

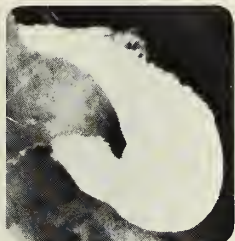
10 mg. capsules, 20 mg. tablets,
10 mg./5 ml. syrup, 10 mg./ml. injection

helps control abnormal motor activity
with minimal anticholinergic side effects[†]

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Bentyl[®]**(dicyclomine hydrochloride USP)**

Capsules, Tablets, Syrup, Injection

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloroduodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage, severe ulcerative colitis, toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur.

ADVERSE REACTIONS: Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSEAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup. **Adults:** 1 or 2 capsules or teaspoonfuls syrup three or four times daily. **Children:** 1 capsule or teaspoonful syrup three or four times daily. **Infants:** ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg. **Adults:** 1 tablet three or four times daily. Bentyl Injection. **Adults:** 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE. MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine[®] (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Decatur, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

July 1979 Morbidity Report

Disease	July 1979 Total	1979 to Date	1978 to Date	Most July Cases Reported From These Counties
Amebiosis	6	63	118	Boone, Madison
Brucellosis	1	3	9	Linn
Chickenpox	49	7050	5642	Scottered
Cytomegalovirus	0	6	15	—
Eaton's Agent infection	3	31	93	Lee, Morsholl, Polk
Encephalitis	5	15	4	Allomokee, Buchanon, Wopello
Erythema infectiosum	0	1071	50	—
Gastroenteritis (GIV)	133	12936	13062	Scottered
Giardiasis	3	21	13	Block Hawk, Boone, Webster
Hepatitis, A	30	128	89	Polk, Scott
Hepatitis, B	14	62	52	Johnson, Polk
type unspecified	7	33	40	Block Hawk, Polk
Herpes simplex	4	41	51	Johnson
Herpes Zoster	0	1	8	—
Infectious mononucleosis	12	375	708	Linn, Story, Tomo, Wopello
Influenza-like illness (URI)	184	40453	40436	Scottered
Meningitis aseptic	6	19	5	Allomokee, Morion, Polk, Wopello
bacterial	11	75	24	Dubuque, Scott
meningococcal	4	9	11	Cerro Gordo, Dubuque, Lee, Polk
Mumps	3	223	122	Block Hawk, Johnson
Pertussis	0	1	1	—
Robies in animals	16	106	82	Josper, Polo Alto, Story
Rheumatic fever	0	10	27	—
Rubello (German measles)	0	51	45	—
Rubeolo (measles)	1	16	54	Linn
Solomonello	22	93	84	Linn, Polk, Winneshiek, Woodbury
Shigello	2	39	22	Bremer, Polk
Tuberculosis total ill	5	47	65	Scottered
bact. pos.	4	40	43	Scottered
Venereal diseases: Gonorrhea	451	3194	3180	Scottered
P. & S. Syphilis	1	24	26	Polk

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Rocky Mountain spotted fever — 1, Block Hawk, 1, Bremer, 1, Pottowottomie; Scarlet Fever — 1, Polk; Typhus Infection — 1, Johnson; Malaria — 1, Osceola; Coxsackie — 1, Polk.

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ABOUT IOWA PHYSICIANS

Dr. Kim P. Petersen has left his Newton practice to become associate director of the Davenport Medical Education Foundation. . . . **Dr. Edward C. Hirl** and **Dr. Stephen Sidwell** have recently entered family practice in Maquoketa. Both physicians are U. of I. graduates. Dr. Hirl had his family practice residency at Broadlawns Hospital in Des Moines and Dr. Sidwell had his at Mercy and St. Luke's Hospitals in Davenport. . . . **Dr. Gary R. Carlton** has joined Sioux City physicians, **Drs. C. A. Jacobs, D. E. Boyle** and **P. J. Monnig**. Dr. Carlton received the M.D. degree at the University of Nebraska College of Medicine; interned and completed his surgery residency at the Veterans Administration Hospital in Lincoln, Nebraska. . . . **Dr.**

Craig Bainbridge has joined **Dr. Dale Wassmuth** to practice internal medicine in Sioux City. Dr. Bainbridge received the M.D. degree; had his internal medicine residency at U. of I. College of Medicine. A Sioux City native, he received two American Lung Association fellowships in pulmonary disease, one at the U. of I., the other at the Cardiovascular Research Institute, University of California, San Francisco. Dr. Bainbridge has co-authored three publications on respiratory disease.

Dr. Thomas Okner and **Dr. Philip Scheinberg** have joined the Wolfe Clinic in Marshalltown. Dr. Okner received the M.D. degree at New York Medical College in Manhattan; interned at Lenox Hill Hospital in New York City; and completed his otolaryngology residency at the Manhattan Eye, Ear, Nose, and Throat Hospital. Dr. Scheinberg received the M.D. degree at the University of Miami School of Medicine in Miami, Florida. Prior to completing his otolaryngology residency at Stanford University, Dr. Scheinberg took postgraduate training at St. Joseph's Hospital in Denver, Colorado and served in the Emergency Room at Denver General Hospital. . . . **Dr. Steven M. Karber** has joined the Jefferson Clinic. Dr.

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Karber received the M.D. degree and completed his internal medicine residency at the U. of I. College of Medicine. . . . **Dr. Warren H. DeKraay** will leave Surgical Associates of Ottumwa on October 1 to enter a cardiovascular training program in Charlotte, North Carolina. Dr. DeKraay began his medical practice in Ottumwa in 1962. . . . **Dr. Joel Kosinski** has joined **Drs. Donald Reading, Robert Mand-sager and Thomas Foley** to practice general surgery in Marshalltown. Dr. Kosinski received the M.D. degree at Northwestern University Medical School in Chicago and completed his surgery residency at U. of I. College of Medicine.

Dr. Narong Jarasviroj has joined Winterset Medical Associates. A native of Thailand, Dr. Jarasviroj had his medical education at the University of Chulalongkorn at Bangkok. Following his U. S. arrival, Dr. Jarasviroj trained at Kansas City General Hospital and had his general surgery residency at Veterans Hospital in Des Moines. . . . **Dr. Steve Richards** has joined **Dr. Jay Mixdorf** at the Kossuth Medical

Center in Algona. Dr. Richards is a graduate of the Des Moines College of Osteopathic Medicine and Surgery and recently completed his family practice residency at Broadlawns Hospital in Des Moines. . . . **Dr. A. E. Mayner**, Winthrop physician, has purchased the medical practice of **Dr. Donald Otilie** in Oelwein. Dr. Otilie, who recently moved to San Diego, California, had practiced in Oelwein since the early 1950s. **Dr. Steve Cook**, a native of Quasqueton, now serving a family practice residency at the Black Hawk Area Family Practice Center in Waterloo, will join Dr. Mayner in Oelwein in July, 1980. . . . **Dr. George M. Paluska**, surgeon, has joined the Family Medical Center in Oskaloosa. Dr. Paluska is a diplomate of the American Board of Surgery and a fellow of the American College of Surgeons.

Dr. Karl Jauch, associate director of the Black Hawk Area Family Practice Residency Program, recently was appointed to the Black Hawk County Board of Health. . . . **Dr. Doug Watts** has joined **Drs. Charles Bendixen and Dave Thomas** to do family practice in Mar-

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shaltown. A native of Marengo, Iowa, Dr. Watts received the M.D. degree at U. of I. College of Medicine and had his family practice residency in Madisonville, Kentucky. . . . **Dr. and Mrs. William Seidler**, Jamaica, recently returned from a two-week trip to Alaska where Dr. Seidler attended a joint meeting of the Alaska Medical Society and the Alaska Academy of Family Physicians. . . . **Dr. Thomas F. Viner** has joined **Drs. C. M. Kos, R. A. Simpson, G. E. McFarland** and **D. M. Roberts** at Otologic Medical Services in Iowa City. A native of Leon, Iowa, Dr. Viner received the M.D. degree at the U. of I. College of Medicine; interned at St. Francis Hospital in Honolulu, Hawaii and completed his otolaryngology and maxillofacial surgery residency at University Hospitals. . . . **Dr. Cyrus L. Beye**, Sioux City and **Dr. Kenneth R. Carrell**, Columbus Junction, have been reappointed to the Iowa State Board of Medical Examiners by Governor Robert Ray. **Dr. Reid E. Motley**, Cedar Rapids, is a new appointee of Governor Ray to the Board. . . . **Dr. C. C. Christiansen** discontinued his medical practice in Grand Mound in July. Dr. Christiansen located in Grand Mound in 1946.

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PRESIDENT'S PRIVILEGE

I recently had the privilege of reviewing patient satisfaction surveys taken among patients visiting four group practices in widely separated areas of the state. In general, the results showed a high level of satisfaction with the medical service received. There were few expressions of dissatisfaction with the care. These results are similar to national patient polls.

A detailed study of the Iowa surveys revealed an interestingly consistent concern of patients about having to wait, and incorporate practice settings, being sure they see the same physician on return visits. The expectancy of having the same doctor seems to be for all time. As expressed by one patient attending a training center, "I did not know the doctors were going to change every three years." In a private practice group, when asked to make a choice between waiting for their "personal" physician or being seen immediately by another physician, 80% indicated they would prefer to wait. It seems evident from these observations that people want a personal identifiable relationship with a physician whom they can call upon when in need. Additionally, although not measured in these surveys, physicians seem to need their own personal identifiable relationship with *their* patients. Just as patients refer to "*my* doctor," doctors invariably use the possessive "*my*" in referring to their patients.

This is not to say patients expect only

one physician to participate in their care. The surveys revealed a high level of expectancy (65%) on the part of patients that in a group practice they might be treated by others than *their own* physician on off hours, in emergencies, etc.

The direct doctor-to-person relationship is at the heart of what Dr. Walsh McDermott, Emeritus Professor of Medicine from Cornell, has labeled "the personal encounter physician system," as distinguished from the public health system. It has been popular in the past decade for writers, economists, health planners and politicians to claim the personal encounter physician system has failed. In its place, the public should invest in what euphemistically has been called alternative health strategies to solve health care problems in the future. These critics have made a serious and fundamental error, they neglected to talk to the patients.

The personal encounter physician system here in Iowa as evaluated by the people who use it—the patients—is held in high regard, so high in fact that all they ask for is more of it. It behooves all of us to work toward its preservation, which seems to require that we keep our services personal and identifiable.

Paul M. Seebohm M.D.

Paul M. Seebohm, M.D.

IN-STATE MEDICAL MEETINGS

- Oct. 5-6** **What Is the Matter with the Heart — Ironmen Inn — Iowa City — Sponsor: American Heart Association, Iowa Affiliate**
- Oct. 12-14** **The Role of Nuclear Medicine in Oncology — Airport Hilton Inn — Des Moines — Sponsor: Iowa Methodist Medical Center**
- Oct. 16** **Gallstones and Biliary Disease — Sponsor: St. Joseph Mercy Hospital and U. of I. College of Medicine — St. Joseph Mercy Hospital — Mason City**
- Oct. 25** **Plasma Exchange — Moline Public Hospital — Moline, Illinois — Sponsor: Mississippi Valley Regional Center, Davenport**
- Oct. 27** **Critical Care Medicine — Sponsor: St. Luke's Methodist Hospital — Cedar Rapids**
- Nov. 14** **Update on Thyroid Disorders — Sponsor: Mercy Hospital Medical Center — Des Moines**
- Nov. 14** **Medical Genetics — Sponsor: U. of I. College of Medicine — Holiday Inn — Burlington**
- Nov. 15-16** **The Healthy Family, Assessment and Intervention — Sponsor: Iowa — Illinois Association for Marriage and Family Therapy — Amana Colonies — Amana**

The following postgraduate courses and conferences will occur at U. of I. College of Medicine in Iowa City

- Oct. 20** **Current Therapy in Neurology**
- Oct. 25-26** **Pediatrics Postgraduate Conference**
- Nov. 2** **Postgraduate Conference on Surgery**
- Nov. 2-3** **Otolaryngology Clinical Conference**
- Nov. 3** **Cancer Teaching Day**
- Nov. 5-9** **Intensive Course in Pediatric Nutrition**
- Nov. 5-9** **Aesthetic Facial Surgery**
- Nov. 8-10** **Psychiatry Postgraduate Conference**
- Nov. 13-14** **Postgraduate Conference on Obstetrics and Gynecology**
- Nov. 16** **Fifth Annual Childhood Cancer Workshop**
- Nov. 30** **Radiation Therapy Seminar**
- Nov. 30-
Dec. 1** **Otolaryngology Clinical Conference**

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Brief Summary

INDICATIONS: For the prevention and treatment of nocturnal recumbency leg muscle cramps, including those associated with arthritis, diabetes, varicose veins, thrombophlebitis, arteriosclerosis, and static foot deformities.

CONTRAINDICATIONS: Because of the quinine content, Quinamm is contraindicated in women of childbearing potential, in pregnancy, in patients with known quinine sensitivity, and in patients with glucose-6-phosphate dehydrogenase deficiency. Hemolysis (with the potential for hemolytic anemia) has been associated with a G-6-PD deficiency in patients taking quinine.

PRECAUTIONS: Thrombocytopenic purpura may follow the administration of quinine in highly sensitive patients. Recovery will follow withdrawal of the medication.

Cinchona alkaloids, including quinine, have the potential to depress the hepatic enzyme system that synthesizes the vitamin K-dependent factors. The resulting hypoprothrombinemic effect may enhance the action of warfarin and other oral anticoagulants.

ADVERSE REACTIONS: Aminophylline may produce intestinal cramps in some instances, and quinine may produce symptoms of cinchonism, such as tinnitus, dizziness, and gastrointestinal disturbance. If ringing in the ears, deafness, skin rash, or visual disturbances occur, the drug should be discontinued.

DOSAGE AND ADMINISTRATION:

1 tablet upon retiring. When necessary, 1 additional tablet may be taken following the evening meal.

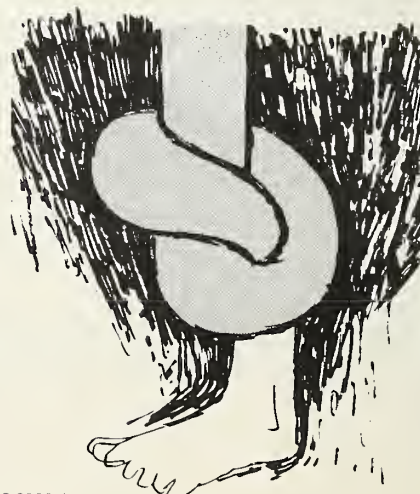
Product Information as of September, 1977
U.S. Patent 2,985,558

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VOX DOCS

Be sure to note the October question below! Give us your opinion. Clip and send your answer to IMS Headquarters. Following are capsule comments on last month's question:

"Joints start wearing out at puberty; they can be replaced. Arteries wear out; some can be replaced. Neurons wear out; they are irreplaceable. Who wants to live to 150 without the upper story?" — *John Rhodes, Sr., M.D., Pocahontas*

"Cell replication is finite in number. Even in the absence of disease the body will eventually wither and die. Extending this limitation depends on as yet undreamed of research and discovery." — *Don Orelup, M.D., Albia*

Unless ways to control senility and ASCVD are found there would be no desire to live to 150. Mechanically a possibility, but not practical with today's knowledge." — *Dan Youngblade, M.D., Sioux City*

"Long live Jonathan Livingston Seagull." — *James Kimball, M.D., Osceola*

"Organ banks are becoming increasingly available. Transplant surgery combined with mi-

LAST MONTH'S QUESTION & RESPONSE

Do you agree with the Russian physician who says the normal life span should be 150 years — if repairable "mechanical breakdowns" are made to the body?

SOUNDS POSSIBLE	48%
HIGHLY UNLIKELY	26%
NEXT TO IMPOSSIBLE	26%

crovascular surgery theoretically could prolong life. It's unlikely any government will approve this as cost-effective except for their leaders." — *Erling Larson, M.D., Davenport*

"Brains and joints won't last. Metabolic changes are not mechanical breakdowns. However, if he can get rid of wrinkles and maintain an active sex life, I might be interested." — *Dennis Walter, M.D., Des Moines*

"All we need to make this possible is to conquer malignant and degenerative disease." — *C. W. Seibert, M.D., Waterloo*

OCTOBER QUESTION

Not one manufacturer reportedly exhibited a CAT scanner at the recent American Hospital Association convention — the largest hospital trade fair in the world. Why? Is this marvel of medical technology just too costly in our hold-the-line inflationary times? Or are government's regulatory demands too onerous to pursue acquisition?

☐ TOO COSTLY

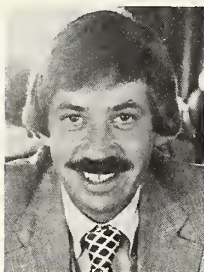
☐ TOO MUCH GOVERNMENT RED TAPE

WHY? _____

NAME _____

ADDRESS _____

Send your opinion to: Editor, IMS JOURNAL, 1001 Grand Avenue, West Des Moines, Iowa 50265



QUESTIONS - ANSWERS

**BERNIE LOWE
DES MOINES**

Mr. Lowe is a vice president of The Prouty Company of Des Moines. This company administers various of the group insurance coverages available to IMS member physicians.

INSURANCE UPDATE

Let's limit our discussion to life insurance here. What guidelines are there as to how much life insurance a physician should own?

This amount depends on a number of factors, including marital status; number and ages of any children (if married); do you have outside investments such as real estate where you need temporary protection?; are you in a partnership or a professional corporation where there is a "buy/sell" or stock redemption agreement which needs to be funded?

Rather than zero in on a specific amount, let's talk about the functions of life insurance and where it can be used to fulfill a physician's various needs. Among these are:

Protection for family, especially during the dependency years of children.

Mortgage redemption protection for home and/or office building if owned by the physician.

Protection for an investment that has yet to mature.

Funding for a "buy/sell" or stock redemption agreement where a physician has partners or is a stockholder in a professional corporation.

Provision for liquid funds to pay estate taxes upon death. This point is especially important since the new law requires the payment of death taxes 9 months after date of death.

Provision of an education fund for children.

Presumably this coverage should be added on an incremental basis as circumstances permit. Is there any rule-of-thumb as to the interval in which an individual should add to his life insurance portfolio?

At a minimum, a physician should review his life insurance program every two years. My reason for recommending this is twofold — one, we have been faced with "double digit" inflation the past few years.

To give you an example of how fast inflation can erode an insurance estate, consider these figures: A person with adequate life insurance in 1971 and who has not purchased additional coverage since will have to increase that coverage by 76% just to keep pace with inflation. This 76% figure does not take into account any increases in your life insurance needs — it simply covers the erosion factor.

Tax law changes in recent years are the other main reason for periodic review. The Tax Reform Act of 1976 has made any estate plan developed prior to its passage virtually obsolete. Those estate plans which have not been reviewed since the passage of that act should definitely be brought up to date.

What are the important distinguishing characteristics between permanent and term insurance? What division should a physician consider between these two types of coverage?

1. Term insurance, as the name implies, is life insurance coverage which spans a specific period of time such as 5 years, 10 years, etc. Term insurance is pure protection. Therefore the "going in" rate at any given age will be much less than the "going in" rate of a permanent type policy purchased at the same age. Term protection is ideally suited for short term need such as a mortgage on a home or office building, protection of a short term investment, and protection during the dependency years of children.

There are basically two types of term cover-

QUESTIONS-ANSWERS

age — level term coverage where the face amount remains level and the premiums increase at various intervals, i.e., annually, every 5 years, or 10 years. The other type of term coverage is reducing term coverage whereby the face amount of the policy reduces each year over the tenure of the policy but the premiums remain level — this latter form of term insurance is used primarily as mortgage protection.

2. On the other hand, permanent insurance offers lifetime protection with the face amount and the premium remaining level throughout the insured's lifetime. In addition to offering life insurance protection, permanent life plans also have cash values which increase each year the coverage is in force. This cash value account can be invaded at any time and is a good source for low interest (5% to 8%) loans. However, the face amount of the coverage is reduced by the amount of the loan outstanding should death occur before the loan is repaid. The cash value account may also be used to supplement retirement benefits once the insured reaches the point where he no longer needs the life insurance protection. Because of the cash values under permanent coverage the "net cost" for this plan will usually be less than the "net cost" for the same amount of term coverage over a period of 10 years or longer.

Permanent insurance is best suited for providing liquidity for Federal or State tax purposes since its cost remains level and term insurance rates after age 60 become prohibitive. Permanent insurance is also ideal for use in supplementing retirement benefits because of the settlement options available under the cash value account.

3. The young and newly practicing physician should buy mostly term insurance. At his stage in life he needs the most protection for the least amount of premium dollars. In purchasing term insurance, however, the young physician should always buy term insurance which allows full conversion to a permanent type plan. This guarantees his/her insurability. As the physician grows older, the term insurance can be eventually converted to permanent life insurance in the amount necessary to maintain an adequate estate.

There has been discussion about life insurance not producing the kind of return other investments do. Can you discuss the matter of insurance as an investment? Is it a good one?

As an investment, life insurance obviously does not offer the return of high grade stocks or bonds; the return of real estate in recent years; or even a high interest bearing certificate of deposit.

Permanent life insurance, however, if purchased at an early enough age will eventually return to the insured the sum of his premiums paid or more, plus it will have provided the person with valuable protection over a given period of years.

The unique thing about life insurance is that it creates an immediate estate with a minimum of dollars. As an example, a physician who is age 25 could purchase approximately \$100,000 of permanent life insurance for a \$1,000 annual premium. If the physician were to die six months after such purchase, then his beneficiary would receive \$100,000 for a deposit of only \$1,000. If, on the other hand, the same 25-year-old physician decided to put the \$1,000 in a 9% yielding certificate of deposit and died in six months his beneficiary would receive the \$1,000 originally invested plus pro-rata interest to date of death which in this case would amount to an additional \$45.

Through the above illustration it is apparent that an adequate life insurance estate should exist before embarking on an investment program. The two programs should not be confused.

Are there any interesting or unique products which have come into the life insurance field in the past year or two that you are aware of?

There have been several new products introduced by life insurance companies in recent years, three of the most important which I have listed below:

A. *Adjustable Life* — This product, offered by The Bankers Life of Iowa and Minnesota Mutual, is by far the most innovative product offered to date. Under the "Adjustable Life" concept the insured has complete flexibility —

(Please turn to page 386)

QUESTIONS-ANSWERS

(Continued from page 385)

he may increase or decrease his premiums as the situation demands; he may increase or decrease the benefit amount; and he may change the contract from a permanent life to term life as he sees fit and all this can be done without the necessity of issuing new policies each time these options are exercised. In addition, an automatic "cost of living" option is built into the contract. Up through age 55, this cost of living agreement provides face amount increases at the end of any three-year period in which the policyholder does not change his policy face amount. The amount of each increase is equal to the percentage increase in the consumer price index for the prior three years, subject to a 20% maximum or \$20,000 (Minnesota Mutual is \$30,000). These increases are provided **WITHOUT EVIDENCE OF INSURABILITY**.

B. Section 79 Permanent Life Insurance — This product in recent years has been surrounded by controversy but final IRS regulations have been issued. Section 79 Permanent Life is available only to those physicians who are professionally incorporated and allows the purchase of personal permanent life insurance on a tax favored basis through the corporation. Space does not allow for complete breakdown of the specifics on Section 79 but it has had very favorable acceptance by those who are incorporated and need additional permanent life insurance personally.

C. Survivor and Joint Life Insurance — This product was designed as an estate planning tool and provides a given amount of life insurance on two people (usually husband and wife). The policy gives equal protection to the insureds during their lifetime and upon the death of the first insured the survivor becomes the beneficiary of a fully paid up policy equal to the initial face amount on both. This policy was designed to cover the situation where little or no estate taxes are due upon the first death but substantial estate taxes become due upon the death of the survivor and liquidity is needed to provide those taxes. The policy, because of its nature, is about one half the cost of buying a policy of equal face amount on each of the insureds individually.

Tenuate®

(diethylpropion hydrochloride NF)

Tenuate Dospan®

(diethylpropion hydrochloride NF) controlled-release

AVAILABLE ONLY ON PRESCRIPTION

Brief Summary

INDICATION: Tenuate and Tenuate Dospan are indicated in the management of exogenous obesity as a short-term adjunct (a few weeks) in a regimen of weight reduction based on caloric restriction. The limited usefulness of agents of this class should be measured against possible risk factors inherent in their use such as those described below.

CONTRAINDICATIONS: Advanced arteriosclerosis, hyperthyroidism, known hypersensitivity, or idiosyncrasy to the sympathomimetic amines, glaucoma. Agitated states. Patients with a history of drug abuse. During or within 14 days following the administration of monoamine oxidase inhibitors, (hypertensive crises may result).

WARNINGS: If tolerance develops, the recommended dose should not be exceeded in an attempt to increase the effect; rather, the drug should be discontinued. Tenuate may impair the ability of the patient to engage in potentially hazardous activities such as operating machinery or driving a motor vehicle; the patient should therefore be cautioned accordingly. **Drug Dependence:** Tenuate has some chemical and pharmacologic similarities to the amphetamines and other related stimulant drugs that have been extensively abused. There have been reports of subjects becoming psychologically dependent on diethylpropion. The possibility of abuse should be kept in mind when evaluating the desirability of including a drug as part of a weight reduction program. Abuse of amphetamines and related drugs may be associated with varying degrees of psychological dependence and social dysfunction which, in the case of certain drugs, may be severe. There are reports of patients who have increased the dosage to many times that recommended. Abrupt cessation following prolonged high dosage administration results in extreme fatigue and mental depression; changes are also noted on the sleep EEG. Manifestations of chronic intoxication with anorectic drugs include severe dermatoses, marked insomnia, irritability, hyperactivity, and personality changes. The most severe manifestation of chronic intoxications is psychosis, often clinically indistinguishable from schizophrenia. **Use in Pregnancy:** Although rat and human reproductive studies have not indicated adverse effects, the use of Tenuate by women who are pregnant or may become pregnant requires that the potential benefits be weighed against the potential risks. **Use in Children:** Tenuate is not recommended for use in children under 12 years of age.

PRECAUTIONS: Caution is to be exercised in prescribing Tenuate for patients with hypertension or with symptomatic cardiovascular disease, including arrhythmias. Tenuate should not be administered to patients with severe hypertension. Insulin requirements in diabetes mellitus may be altered in association with the use of Tenuate and the concomitant dietary regimen. Tenuate may decrease the hypotensive effect of guanethidine. The least amount feasible should be prescribed or dispensed at one time in order to minimize the possibility of overdosage. Reports suggest that Tenuate may increase convulsions in some epileptics. Therefore, epileptics receiving Tenuate should be carefully monitored. Titration of dose or discontinuance of Tenuate may be necessary.

ADVERSE REACTIONS: **Cardiovascular:** Palpitation, tachycardia, elevation of blood pressure, precordial pain, arrhythmia. One published report described T-wave changes in the ECG of a healthy young male after ingestion of diethylpropion hydrochloride. **Central Nervous System:** Overstimulation, nervousness, restlessness, dizziness, jitteriness, insomnia, anxiety, euphoria, depression, dysphoria, tremor, dyskinesia, mydriasis, drowsiness, malaise, headache; rarely psychotic episodes at recommended doses. In a few epileptics an increase in convulsive episodes has been reported. **Gastrointestinal:** Dryness of the mouth, unpleasant taste, nausea, vomiting, abdominal discomfort, diarrhea, constipation, other gastrointestinal disturbances. **Allergic:** Urticaria, rash, ecchymosis, erythema. **Endocrine:** Impotence, changes in libido, gynecomastia, menstrual upset. **Hematopoietic System:** Bone marrow depression, agranulocytosis, leukopenia. **Miscellaneous:** A variety of miscellaneous adverse reactions has been reported by physicians. These include complaints such as dyspnea, hair loss, muscle pain, dysuria, increased sweating, and polyuria.

DOSE AND ADMINISTRATION: Tenuate (diethylpropion hydrochloride): One 25 mg. tablet three times daily, one hour before meals, and in mid-evening if desired to overcome night hunger. Tenuate Dospan (diethylpropion hydrochloride) controlled-release: One 75 mg. tablet daily, swallowed whole, in midmorning. Tenuate is not recommended for use in children under 12 years of age.

OVERDOSEAGE: Manifestations of acute overdosage include restlessness, tremor, hyperreflexia, rapid respiration, confusion, assaultiveness, hallucinations, panic states. Fatigue and depression usually follow the central stimulation. Cardiovascular effects include arrhythmias, hypertension or hypotension and circulatory collapse. Gastrointestinal symptoms include nausea, vomiting, diarrhea, and abdominal cramps. Overdose of pharmacologically similar compounds has resulted in fatal poisoning, usually terminating in convulsions and coma. Management of acute Tenuate intoxication is largely symptomatic and includes lavage and sedation with a barbiturate. Experience with hemodialysis or peritoneal dialysis is inadequate to permit recommendation in this regard. Intravenous phentolamine (Regitine®) has been suggested on pharmacologic grounds for possible acute, severe hypertension, if this complicates Tenuate overdosage.

Product Information as of April, 1976

MERRELL-NATIONAL LABORATORIES Inc.

Cayey, Puerto Rico 00633

Direct Medical Inquiries to:

MERRELL-NATIONAL LABORATORIES

Division of Richardson-Merrell Inc.

Cincinnati, Ohio 45215, U.S.A.

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References: 1. Citations available on request from Medical Research Department, MERRELL-NATIONAL LABORATORIES, Cincinnati, Ohio 45215. 2. Hoekenga, M.T., O'Dillon [Dillon], R.H., and Leyland, H.M.: A comprehensive review of diethylpropion hydrochloride. In, *Central Mechanisms of Anorectic Drugs*, S. Garattini and R. Samanin, Ed., New York, Raven Press, 1978, pp. 391-404

Merrell

Rural Health Care Around the World

ROBERT LOUIS STAUTER, M.D.

Iowa City, Iowa

AS AN ALTERNATIVE to a multi-disciplinary senior year at The University of Iowa College of Medicine, I elected to view and participate in rural health care delivery at four different sites in the world. This off-campus senior experience was completed between October 1977 and June 1978.

RURAL SCOTLAND — GENERAL PRACTICE

My first elective was two weeks with a general practitioner in a small community of 800 people in western Scotland along the peninsulas and islands of the Atlantic Ocean.

As a student I made daily hospital rounds with my preceptor. Hospital services consisted of chronic and emergency out-patient care. No surgical facilities are available: all surgical cases are referred to nearby hospitals (40 miles away) or to the university center of Glasgow (over 100

This report was prepared by Dr. Stauter based on his experience with a senior elective program at The University of Iowa College of Medicine. He is now in residency training at the Akron General Medical Center in Akron, Ohio.

An Iowa farm experience helped this senior medical student with an obstetrical case in Australia. He describes a year's senior study abroad which took him also to Scotland, India and the Philippines.

miles away). Transport of patients is by private car or government ambulance.

Office hours were held every morning. Afternoons were reserved for making house calls. I accompanied the doctors on home visits. I was frankly surprised to see how *little* can be done therapeutically with only simple diagnostic equipment and selected pharmaceuticals in the medical bag. Most house calls ended simply as social visits with the doctor.

The government nursing service regularly visits local people who are in need of care that can be provided at home, e.g., blood pressure checks, bandage changes, well baby checks. The nurse visits the general practitioner bi-weekly to spend about an hour reporting cases, discussing problems, or requesting the doctor to make a home visit.

Professors from Glasgow, representing most specialties, hold monthly clinics at the local hospital. Patients are followed in these clinics, averting a long drive to the city. Again limited

THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE
AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF OCTOBER 1979.

diagnostic facilities render the clinic less effective.

The month of November was spent in Scotland on an island of the Outer Hebrides. I was in the island's main village where there are 25 cottage hospital beds for a village population of 3000. The three general practitioners with whom I worked are responsible for patients in the northern half of the 30-mile long island. Patients in the local hospital are treated for non-surgical acute problems. For surgical care transfer is made to a hospital 15 miles away or to Inverness on the mainland when tertiary referral care is needed. The transfer to the mainland requires use of either a regularly scheduled ferry during the day or a special ferry run during an emergency evacuation at night. Alternatively, the Royal Air Force will dispatch a helicopter to the area. By this means a patient can be reached within two hours; such action is reserved for injuries occurring far from regularly travelled areas (mountain climbing accidents or accidents at sea).

I visited two rural outpatient practices attended weekly by one of the doctors. One is in a small village of 400 people about 10 miles north of the hospital, and the other on a nearby island with a population of 200.

The doctors were frustrated working these clinics, primarily because laboratory samples have to be returned to the base hospital for analysis. But they agree that such weekly clinics probably eliminate the need for many home visits.

Normal childbirth is handled by the midwife at the cottage hospital, with assistance as needed from the general practitioner. Cases with foreseen complications are referred to the nearby surgical hospital or to the Inverness Obstetrical Department.

The local people take great pride in their hospital and medical staff. Even though I considered this to be a very rural place, I met a patient who had driven a small power boat for four hours to seek medical attention for a severely painful ear that had developed while he was working on a cable construction ship off the island's coast. He made reference to his boat ride as "a trip to the city."

SOUTHERN INDIA — RURAL PEDIATRICS

By working in a private medical center in southern India, I completed a six-week senior elective assignment with the Pediatrics De-

partment. Most of my time was spent at a rural hospital participating in daily clinics. Each morning clinic was staffed by three interns from the local university center and by the staff doctor of the rural health department. Thirty to 75 patients were seen every morning. The patients' problems were predominantly infectious diseases. Common presenting symptoms included diarrhea, respiratory distress and carbuncles. In a three-hour clinic, I saw children with clinically diagnosed (and later laboratory-proved) whooping cough, cholera, tetanus, polio, malaria, and later in the week, an infant with rabies. These were six diseases I had never seen. The clinic also had a small pharmacy and a laboratory for complete blood counts and urinalyses. Outpatient surgery was performed including incision and drainage of abscess, tubal ligation, vasectomy, and biopsy. Three afternoons a week public health nurses visit the rural villages. They follow-up on treatment schedules for patients with tuberculosis and leprosy; do well baby exams; and once a week the clinic doctors join them to conduct leprosy screening clinics in the rural areas.

Three mornings a week were allotted to inpatient rounds with staff and housestaff physicians consisting of bedside discussions of new and interesting cases. These discussions commonly included problems of health care in the village, often complicated by religious ritual. I saw a child with meningitis, septic arthritis, and osteomyelitis, all secondary to a measles infection. In this case the parents were villagers who believed their child was touched by God when she developed the rash of measles. During the time of the rash it is custom to abandon the child in the temple. When the child's mother returned to her at a time when the rash should have cleared, she found the child very ill. The mother (against the will of the other villagers) brought the child to the local hospital. The staff doctors stressed how important a measles immunization program could be. They resented their government's expenditure of time and money on the political arguments of birth control.

My final week in India was spent in pediatric surgery. We scheduled elective surgery three mornings a week, and on the other two days scheduled clinics for pre- and post-operative patients. In the operating rooms I was amazed to see hospital gowns, syringes, gloves and

other equipment being re-used and re-sterilized. I was so used to disposable supplies I found it hard to believe such supplies could be sterile.

This hospital offers no ambulance services. The wealthy people use their personal automobiles for transport to the hospital, and the poorer people depend upon bicycle-driven rickshaws or public bus transportation. Some very determined people walk long distances to seek medical care and supplies.

AUSTRALIA — THE ROYAL FLYING DOCTOR SERVICE

Early April I settled into a small community of 3,000 people in northwestern Australia for a five-week rotation with the Royal Flying Doctor Service. One half of the town's population is of European descent and the other half aboriginal.

The hospital has about a 100-bed capacity and is staffed by four general practitioners, a pediatrician, and a general surgeon. This single hospital serves the population of 15,000 people within a 400 mile radius.

A typical day included a half hour radio program to contact the people working on the cattle stations. The cattle stations are all equipped with two-way radios for communication. Some of the large stations that also include aboriginal reserves (public housing) have a resident public health nurse. The nurse asks the doctor for medical advice during the program and advises families as to the condition of their relatives in the hospital. Medical communication from the smaller cattle stations is usually carried out by the wife of the station manager.

Each station has a medical chest stocked to a specific protocol of the Royal Flying Doctor Service (RFDS). The RFDS sets up regular clinics at most of the cattle stations, and at any time can arrange emergency evacuations from these areas. Specific cattle stations, which have a runway available, are designated as landing sites. Other nearby stations use their own vehicles to transport patients to the stations with landing strips. A Land Rover ambulance is usually used within a 100-mile radius of the hospital.

I was given more responsibility in Australia than in the previous electives. I was usually on-call every night until midnight and would staff the out-patient department until 10 p.m. each weekday evening. The most common

problems during the outpatient hours were children with respiratory distress or minor traumatic injuries.

It was common to be approached in the only local pub by patients who had been under treatment in the hospital, but who had left against medical advice. At this time they were interested in consulting me concerning suture removal, cast repair and other problems. Several times I was awakened when the pub closed at 2 a.m. and asked to come from home to the hospital to tend to the wounds of someone hurt in a late night brawl.

One memorable episode involved a frantic phone call at 3 a.m. from a midwife in the delivery room. As I put on my clothes and raced to the hospital, I thought that it was a little ridiculous for me, with my total of 25 assists on deliveries, to be running to give consultation to a midwife with over 400 deliveries. As I entered the delivery room, I saw the nurse tending to a blue, flaccid baby, and an anxious mother. While the nurse helped the mother, I started to work with the baby. A quick history from the nurse revealed the mother had been given a dose of narcotic analgesia shortly before a rapid delivery. I gave the baby Narcan, and the sedation was rapidly reversed. The child began to breathe spontaneously. Just as I sighed with relief, the nurse pointed out the mother was bleeding vaginally and the placenta had not completely separated. It had been 15 minutes since birth. I had never been in this situation before although I had read about it many times. I put on a sterile glove, reached up into the uterus (to the amazement of the patient, I might add), and after making sure that the placenta was free all the way around, I grabbed one edge and pulled it out. When the placenta was delivered, I put my hand back into position to slow the bleeding. With a little gentle abdominal massage, the uterus became firm and the bleeding stopped. When the situation seemed under control, the nurse asked me if the placental maneuver I had performed was called the "Dublin method." I explained I was not sure what it was called, but that I had learned it in Iowa, on the farm.

SOUTHERN PHILIPPINES — RURAL PREVENTIVE MEDICINE

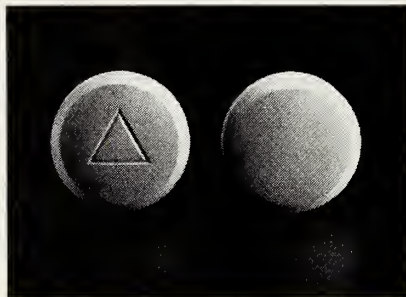
My final elective was a week with a rural health clinic on an island in the southern part of the Philippines. The clinic is sponsored by a private medical school on the island. Each

The Maker

Examining a Few Myths About Prescribing.

Increasing pressure is being put on the practicing physician to prescribe drugs generically. You are told that brand-name products are universally “expensive” and generic versions are relatively “cheap.” To make this case, the most extreme (rather than typical) price differentials are cited. Thus, consumers are led to believe that such differentials are commonplace. Even your knowledge and your motives as a physician are questioned.

Understandably, these views have created myths. We think it's time to examine them in the light of all the facts and ramifications.



MYTH: There are no differences in quality and performance between brand-name products and their generic counterparts. The corollary is that there are no differences among products made by high-technology, quality-conscious, research-based companies and those made by commodity-type suppliers.

FACT: The Food and Drug Administration does a good job in monitoring a generally excellent drug supply. Still, it has nowhere near the resources to guarantee the quality and bioavailability of all marketed products at any given time. Just a few months ago, for example, it noted that batches of tetracycline HCl capsules which met official monograph requirements were

not bioequivalent to a reference product. As you know, there is substantial literature on this subject affecting many drugs, including such antibiotics as tetracycline and erythromycin. The record on drug recalls and court actions affirms strongly that there are differences among pharmaceutical companies and their products. Research-intensive companies have far better records than those that do no research and may practice minimum quality assurance.

MYTH: Industry favors only “expensive” brand names and denigrates all generics.

FACT: PMA companies make 90 to 95 percent of the drug supply, including, therefore, most of the generics. Drug nomenclature is not the important point; it's the competence of the manufacturer and the integrity of the product that count.

Matters.

MYTH: *Generic options almost always exist.*

FACT: About 55 percent of prescription drug expenditure is for single-source drugs. This means, of course, that for only 45 percent of such expenditure, is a generic prescribing option available.

MYTH: *Generic prescriptions are filled with inexpensive generics, thus saving consumers large sums of money.*

FACT: Market data show that you invariably prescribe—and pharmacists dispense—both brand and generically labeled products from known and trusted sources, in the best interest of patients. In most cases the patient receives a proven brand product. Savings from voluntary or mandated generic prescribing are grossly exaggerated.

MYTH: *Drugs account for a major portion of the rise in health care costs.*

FACT: Drugs represent a very small part of such costs. The amount of the health care dollar spent for prescription drugs was about 12 cents in 1967; today it is about 8 cents. And you as a physician are most conscious of how drug therapy can cut hospitalization, avert surgery, reduce office visits and keep patients on the job.

MYTH: *Government intrusions into the marketplace will save tax money.*

FACT: Government schemes always cost the taxpayer something, and the costs often exceed the benefits. Certainly, any federal “help,” such as lists of wholesale drug prices sent to all physicians and pharmacists, will be no exception. Just think of the expense of keeping them current! Moreover, wholesale prices are poor guides to actual transaction prices and even worse guides to retail prices.

The PMA Position

We believe your freedom to prescribe, either by generic or brand name, should be totally unabridged. Otherwise, your prescribing prerogatives and your relationships with patients will be seriously impaired.

The maker does matter

After the myths about price and equivalency have been shattered, one fact stands out more clearly than ever: *The maker does matter.* As always, your best guide to drug therapy for your patients is to select products—both brands and generics—from manufacturers with credentials and performance records you have come to respect.



Pharmaceutical Manufacturers Association
1155 Fifteenth Street, N.W.
Washington, D.C. 20005

medical student is required to spend six weeks at the rural clinic. We saw very few patients at this clinic. Most of our time was spent on preventive health surveys. The studies included general population distribution, living conditions, primary sources of water supply, and what the various neighborhoods did with their waste. Most interesting was living with the other medical students. There were 10 students, five men and five women. The women were from upper-middle class families in the city, and the men were from poor families on the surrounding islands. The men had limited financial support, so tried to live cheaply. We would go to the beach in the evenings to help fishermen pull in their nets. In return, the fishermen supplied us with fish for dinner. We spent most of our free time swimming and talking. They were interested in my stories of life in America and from them I learned a thousand ways to gather, prepare, and eat coconut, pineapple and fish.

From a year as a senior medical student, studying rural health care in Scotland, India, Australia, and the Philippines, I am able to

appreciate some common experiences among the people served by such health care delivery systems. Patients in each of these environments enjoy a personal relationship with their physician. They often know him outside the practice setting. Small communities have a lot of pride in their ability to support a local hospital. Most people are very demanding of this local primary care, yet are also aware of the meaning of referral care and understand the need to be moved to hospitals where more specialized facilities are available. Rural clinics are an effective means of screening large inaccessible populations; but because diagnostic equipment and personnel (radiology, pathology) are usually not available, such clinics are not an efficient way to provide secondary consultation services to a rural area.

I now believe international experience in medicine is very valuable in trying to anticipate the future of America's health care systems; and I would hope that medical school administrators will assist students in developing such elective programs.


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Preliminary Communication: EMT and the Glasgow Coma Scale

S. RANDY WINSTON, M.D.

Des Moines, Iowa

Use of the Glasgow Coma Scale is described briefly. In wide use the GCS provides a scoring system with which to assess the condition of a trauma victim. The GCS is now coming into use by the emergency medical technician.

THE HEAD is injured in more than two-thirds of all automobile accidents, and correspondingly brain injury is the cause of death in about 70% of all fatal cases.¹

In a group of 100 patients with serious head injury studied in Richmond² nearly half were found to be suffering from one or more systemic problems (hypotension, anemia, hypoxia, hypercarbia) at the time of admission. This study and others led the authors to suspect the high incidence of systemic insult was commonplace in the early phase between injury and admission to the hospital, a period described as the "therapeutic vacuum."

While we await full implementation of paramedic legislation and support for a regional and sub-regional trauma center concept, the severity of central nervous system

(CNS) injury has fostered research into this prehospital phase of trauma victim management. Protocols have been developed directed toward the emergency medical technician (EMT) trained in basic life support.

The objective with each CNS injured patient is stabilization of the involved vital systems, prevention of further injury, and reduction of intracranial and/or intraspinal pressure. This is a tall order with the limitations presently imposed on the EMT-A.

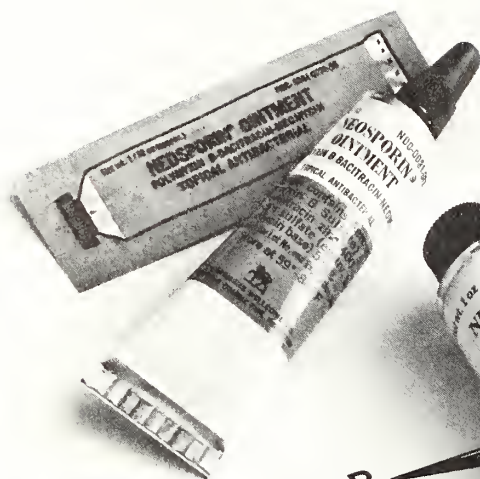
(Please turn to page 398)

TABLE 1
GLASGOW COMA SCALE

EYES	OPEN	Spantaneously	4
		To verbal command	3
		To pain	2
	NO RESPONSE	1	
BEST MOTOR RESPONSE			
	TO VERBAL COMMAND	Obeys	6
		Localizes pain	5
	TO PAINFUL STIMULUS	Withdraws	4
		Abn. Flexian	3
		Extension	2
		Na response	1
BEST VERBAL RESPONSE			
		Oriented and converses	5
		Disoriented and canverses	4
		Inappropriate words	3
		Incomprehensible saunds	2
		No response	1
		TOTAL	

Dr. Winston is in the private practice of neurosurgery in Des Moines, Iowa.

IT'S HIGHLY RECOMMENDED... AND FOR GOOD REASONS



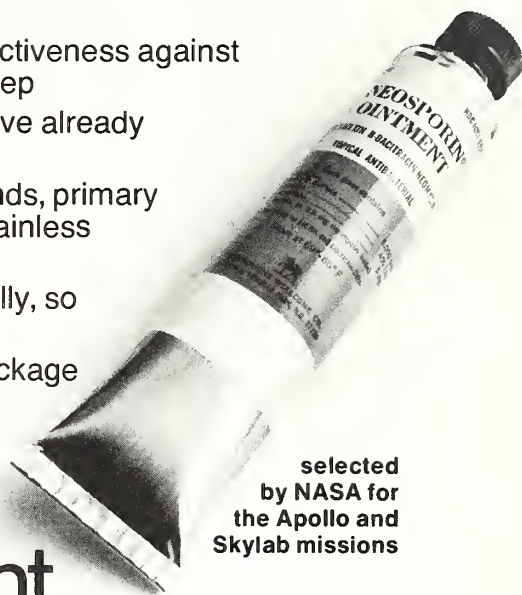
Polymyxin B

Neomycin

Bacitracin

Gram-negative
Pseudomonas
Hemophilus
Klebsiella
Aerobacter
Escherichia
Proteus
Gram-positive
Corynebacterium
Staphylococcus
Streptococcus
Pneumococcus

1. provides broad-spectrum, overlapping antibacterial effectiveness against common susceptible pathogens, including staph and strep
2. helps prevent topical infections, and treats those that have already started
3. it's good medicine for abrasions, lacerations, open wounds, primary pyodermas, secondarily infected dermatoses; and it's painless and cosmetically pleasing
4. contains three antibiotics that are rarely used systemically, so the risk of sensitization is minimal
5. you can recommend it in any of the three convenient package sizes: 1 oz tube, 1/2 oz tube, or the versatile, single-use foil packet



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WARNING: Because of the potential hazard of nephrotoxicity and ototoxicity due to neomycin, care should be exercised when using this product in treating extensive burns, trophic ulceration and other extensive conditions where absorption of neomycin is possible. In burns where more than 20 percent of the body surface is affected, especially if the patient has impaired renal function or is receiving other aminoglycoside antibiotics concurrently, not more than one application a day is recommended.

When using neomycin-containing products to control secondary infection in the chronic dermatoses, it should be borne in mind that the skin is more liable to become sensitized to many substances, including neomycin. The manifestation of sensitization to neomycin is usually a low grade reddening with swelling, dry scaling and itching; it may be manifest simply as a failure to heal. During long-term use of neomycin-containing products, periodic examination for such signs is advisable and the patient should be told to discontinue the product if they are observed. These symptoms regress quickly on withdrawing the medication. Neomycin-containing applications should be avoided for that patient thereafter.

PRECAUTIONS: As with other antibacterial preparations,

prolonged use may result in overgrowth of nonsusceptible organisms, including fungi. Appropriate measures should be taken if this occurs.

ADVERSE REACTIONS: Neomycin is a not uncommon cutaneous sensitizer. Articles in the current literature indicate an increase in the prevalence of persons allergic to neomycin. Ototoxicity and nephrotoxicity have been reported (see Warning section).

Complete literature available on request from Professional Services Dept. PML.



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COMMENTING EDITORIALY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

A RUSTIC CHAIR REVISITED

Several years ago I wrote of a rustic chair built against some huge rocks at the bend of a small river in the Colorado mountains.* That chair was an inspiration to me; an escape from the complexities of civilization. It was a delight to sit by the noisy little stream; to visualize the mountains overgrown with pine trees and many colorful flowers, the cloud-festooned blue sky; to meditate upon the beautiful bounties of life. I had referred to it as an "altar for communion with nature and the Omnipotent."

Last month I sought for that chair again. The pathway through the woods was strewn with litter, the stream was not the same, and the chair was gone. The ravages of high waters had changed the contour of the stream edges; the chair had been washed away. That discovery proved to be significant; so much else had changed. The consequences of "progress" had taken its toll, for the entire area was no longer the same. In his destructive way, man had left

*Alberts, M. E.: Thanks to rustic chair. *J. Iowa Med. Soc.*, 66:451-452, 1976.

A READER COMMENTS

I really enjoy your little editorials. Today's kids are taught lab, lab, lab, and give plenty of medicines. The latest and most expensive antibiotic is the best, of course! I see that 10 days of Mandol® is \$530.

We have had U. of I. and Mayo students with us for many (± 25) years. Nobody wants to know costs.

his usual mark. Litter of beer cans, aluminum foil, styrofoam cups, and more obnoxious things had replaced many of the tiny flowers. The sound of power saws and hammers penetrated the woods as new homes replaced the previously secluded sanctuary. Reality struck boldly as I became aware one must go deeper yet into the woods to be alone with the wonders of nature.

I do not deny that beautiful homes in the mountain slopes of Colorado are undesirable. I envy those who may live above the dust and smog of the cities and wind-eroded flatlands. Fortunately, most of the homes I saw did blend well into the trees and rocks, and there remained a degree of rustic aura about them. The large piles of cut wood for fireplaces attested that everything had not become ultra modern.

At this time of year when the lush growth of spring and summer peaks and the dormancy of the colder months approaches, we must again allude to the mysteries of nature and life itself. Life does go on and on. Progress dictates that some things are replaced by others. Man dies; infants are born. On and on we go forward seeking new horizons. Mountain streams change their courses, moving aside whatever may be an impediment to the ongoing progress. We deal with the impediments in our pathways, hopefully so the new will be better and more fulfilling. Such a great adventure it becomes, and it is good. I'm sure that farther upstream, higher in the mountains, closer to the clouds, another rustic chair beckons the passer-by. I hope to find it some day when I have the opportunity; for it is good to have goals tempered with humility, and with the knowledge that while life is fleeting, the beauties of nature are there for all of us to behold. — M.E.A.

I ran the emergency room and CCU a few weeks ago and spent some time there with a man having hypotension and myocardial failure. The next day I noticed the young attending ordered a serum magnesium and a serum phosphorus, whatever for, I have no idea.

Dr. Seebohm and the guys down there have to start hammering that when they get to us, it's too late. — WILLIAM E. OWEN, M.D., *St. Ansgar*



OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

A CORE LIBRARY

During the past decade a group of dedicated medical librarians has generated and revised an "Iowa Core List of Books and Journals" to help Iowa practitioners and hospital staffs with their reading needs. Since the overwhelming majority of physicians continue to feel that reading is their prime technique for continuing medical education, I properly acknowledge here the debt we owe to the printed word. And I should do what I can to facilitate your reading.

Under the direction of the State Medical Librarian, Pamela Clark Rees, a group of Iowa medical librarians in April, 1979 published a new version of this core list. It looks to be a very useful resource. The State Medical Library mailed a copy to each Iowa hospital. A few of you might perhaps have seen it, but items of that kind too seldom trickle through a system to the intended users. If you feel interested, you can obtain a copy by writing Iowa State Medical Library, State Historical Building, Des Moines, Iowa, or call 800/362-2384.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

AUXILIARY CONFAB

A highlight of the IMS Auxiliary will occur October 24 with the presentation of a Symposium on Leadership at Society Headquarters. The day-long session is open to all interested members of the Auxiliary.

Keynote speaker will be Mrs. Rolland Grefe,

There are many fine options listed, and some of the items are even free. The entire bundle of wide-ranging books and journals would cost approximately \$2,600. That great an expenditure would not likely be necessary, however, since many physicians already hold some of the items they would desire for their personal libraries, and many of the hospitals have the listed items or equivalents in their present library.

I appeal to each Iowa physician to check the resources available to you at the hospital where you practice. Every Iowa hospital ought to have up-to-date reference material readily available. The smaller hospitals (and this list was really designed with hospitals of 100 beds or less in mind) probably will not have a full- or even a part-time librarian, and so at least one interested physician, or a small committee, ought to monitor the quality and quantity of books and journals available to all the hospital's staff. And when you're at it, think also about the resource material appropriate for the non-physician staff. Choosing that material will be fairly easy because this new core list has such items on it, and you can get lots of help from the State Medical Library and its staff.

Smaller hospitals that currently provide their staffs no service from a hospital librarian might well consider spending part of a book budget for even part-time help to assist its staff to locate quickly the materials it needs. And rather than accumulate an impressive cache of books and materials that are rarely if ever used, a hospital might better use some of its funds to pay for telephone and copying services. Fortunately, the State Medical Library provides a toll-free telephone plus other professional services gratis to the user.

But whatever the support system — Read! Read! Read!

national president of the American Association of University Women. Presentations are planned on a variety of subjects, including political action, nutrition, time management, aging, communication, and parliamentary procedure.

A special feature will have to do with the "Shape Up For Life" campaign of the American Medical Association Auxiliary.

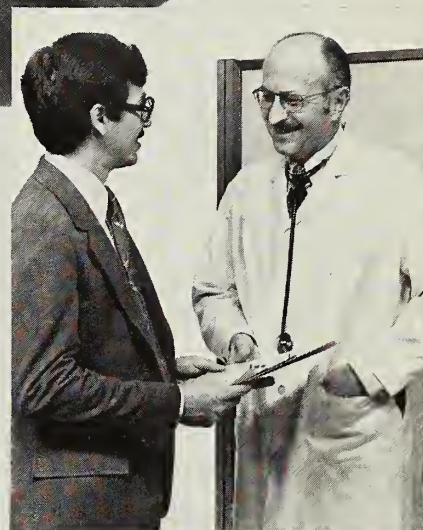


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PRELIMINARY COMMUNICATION: EMT AND THE GLASCOW COMA SCALE

(Continued from page 393)

Nevertheless, it is recognized the initial neurologic assessment at the site of injury and continuing observation en route, communicated to the base hospital can alert the emergency room staff to mobilize necessary personnel to be ready to provide immediate ongoing care of these patients.

Ongoing assessment of trauma patients can be aided through the use of the Glasgow Coma Scale.³ This scale (Table 1) is now a world wide standard by which the observer can easily as-

sess impaired consciousness in three areas: eye opening, best motor response and verbal response. This method is not intended to replace usual vital signs, description of gross injury, pupils, etc. However, its point system (the score range is from three to fifteen) is potentially useful in making an assessment. The higher the score, the more responsive the victim. The Glasgow Coma Scale is now being used in EMS primary training and in EMS continuing education seminars.

REFERENCES

1. Kihlberg, J. K.: Head injury in automobile accidents, in Caveness, W. E., and Walker, E. A. (Eds.): Head Injury. Philadelphia, J. B. Lippincott Co., 1966, pp. 27-36.
2. Miller, J. D. *et al*: Early insults to the injured brain. *JAMA* 240:439-442, 1978.
3. Jennett, B., and Teasdale, G.: Aspects of coma after severe head injury. *Lancet* 2:878-881, 1977.

August 1979 Morbidity Report

Disease	August 1979 Total	1979 to Date	1978 to Date	Most August Cases Reported From These Counties
Amebiasis	6	69	125	Boone
Brucellosis	1	4	9	Tomo
Chickenpox	35	7085	5660	Johnson, Dubuque
Cytomegalovirus	2	8	15	Johnson, Polk
Eaton's Agent infection	4	35	104	Butler, Dollos, Poweshiek, Wapello
Encephalitis	30	45	8	Linn, Wapello, Wayne
Erythema infectiosum	0	1071	50	—
Gastroenteritis (GIV)	215	13151	13280	Scattered
Giardiasis	6	27	17	Boone, Emmet, Polk
Hepatitis, A	11	139	101	Des Moines, Polk
Hepatitis, B	6	68	65	Polk, Osceola
type unspecified	5	38	43	Polk, Scott
Herpes simplex	8	49	60	Cerro Gordo, Johnson, Linn, Polk
Herpes Zoster	0	1	8	—
Histoplasmosis	2	2	3	Polk
Infectious mononucleosis	27	402	733	Polo Alto, Story, Tomo
Influenza, lab confirmed	0	34	175	—
Influenza-like illness (URI)	317	40770	39219	Scattered
Meningitis aseptic	14	33	14	Boone, Polk, Wayne, Webster

Disease	August 1979 Total	1979 to Date	1978 to Date	Most August Cases Reported From These Counties
bacterial	9	84	30	Benton, Boone, Greene, Johnson, Polk, Scott
meningococcal	0	9	12	—
Mumps	5	228	122	Dubuque, Hamilton, Scott, Story
Pertussis	1	2	1	Woodbury
Robies in animals	22	128	96	Colhoun, Marshall, Story
Rheumatic fever	0	10	28	—
Rubella (German measles)	1	52	48	Cloy
Rubeola (measles)	0	16	55	—
Salmonella	18	111	118	Johnson, Linn, Polk, Scott
Shigella	10	49	29	Johnson, Polk, Scott
Tuberculosis total ill	5	52	72	Linn, Polk, Story, Tomo
bact. pos.	5	45	50	Linn, Polk, Story, Tomo
Venereal diseases:				
Gonorrhea	769	3963	3684	Scattered
P. & S. Syphilis	3	27	28	Benton, Johnson, Woodbury

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Guillain Barré — 1, Osceola; Scarlet Fever — 2, Polo Alto; Kowosaki — 1, Emmet; Echovirus — 1, Cloyton, 1 Jackson, 3 Johnson, 1 Polk, 2 Scott, 1 Wapello, 1 Wayne, 1 Winneshiek, 1 Unknown county.

STATE DEPARTMENT/ PUBLIC HEALTH

INDOCHINESE REFUGEES

Indochinese refugees are entering Iowa in increasing numbers and will be presenting to the medical community for additional care and follow-up. The following article is by the Center for Disease Control. It reviews the health status of refugees and makes recommendations for their care and treatment after arrival in the United States. The Iowa State Department of Health recommends complete physical examinations on all entering refugees. This includes chest examination for tuberculosis — Mantoux test is recommended instead of the tine test.

If questions arise in the management or treatment that are not answered by this statement, please contact either of the two following individuals at the Iowa State Department of Health for assistance: *L. A. Wintermeyer, M.D., State Epidemiologist and Director of Infectious Disease Section (515/281-5424), or Russell W. Currier, D.V.M., Chief, Division of Disease Prevention (515/281-5643).*

CDC REPORT

Fourteen thousand Indochinese refugees are now being accepted monthly for resettlement in the United States. Within the Public Health Service (PHS), CDC shares federal responsibility for the health of refugees with the Health Services Administration (HSA). CDC is responsible for the medical screening of refugees while they are still abroad and for the inspection of refugees upon arrival at U. S. ports of entry. By law, health screening of refugees in Asia includes examination for tuberculosis, leprosy, venereal disease, and mental defects and disorders.* The HSA provides — or helps private, local, or state sources provide — im-

mediate medical services, as well as a more comprehensive medical assessment of refugees after their arrival in the United States. State and local health departments are being notified of the arrival of each refugee to their communities. Both CDC and HSA are seeking to insure that adequate documentation on refugees with special health problems is acquired and distributed to state and local health authorities.

PHS teams have recently visited areas in California, Oregon, Washington, and Hawaii that have already received large numbers of refugees, as well as refugee camps and embarkation areas in Southeast Asian countries. From these visits, as well as from limited surveillance data and the experience gained in the resettlement of over 150,000 Vietnamese refugees in the United States since May 1975, the following may be expected:

1. *The majority of refugees will be free of major contagious diseases;*
2. *Where an illness is present, it will likely represent a personal rather than a public health problem, and;*
3. *The main health problems, perhaps exceeded only by the stress of resettlement itself, will include tuberculosis and parasitic diseases.*

This report represents a summary of recommendations that have been prepared by CDC as a guide to practitioners and state and local health departments concerning some of the more significant infectious disease problems that may be encountered. As surveillance information becomes available, these data will appear in the *MMWR*.

TUBERCULOSIS

Tuberculosis is the most serious potential public health problem of Indochinese refugees. Data from San Francisco, Los Angeles, and the state of Washington, indicate that 1%-2% of refugees who have arrived during 1979 and have been examined have been found to have "active" tuberculosis. This estimate may be high because refugees in whom tuberculosis was identified overseas are more likely to have been examined upon arrival in the United States than other refugees. In San Francisco, 41% (136 of 333) of refugees less than 18 years of age had a skin test that was positive for tuberculosis. In Los Angeles and Washington state, about half of the refugees — of all age groups — had a positive skin test. The propor-

tion who had received BCG vaccination is not known.

Screening and Notification Procedures

At present, refugees 2 years and older are screened in the refugee camps in Southeast Asia with a chest X ray. * "Active" or suspected "active" (Immigration Class A+) tuberculosis is an excludable condition. Refugees so classified must remain in Asia under treatment until their disease is no longer "active," unless excludability is waived. Persons with Class A tuberculosis who are eligible for a waiver of excludability can travel immediately if their disease is non-contagious. If their disease is contagious they must remain under treatment in Asia until their disease is judged non-contagious. Refugees classified as having "active" or suspected "active" (Class A) tuberculosis or tuberculosis "not considered active" (Class B), are referred for medical evaluation upon arrival. In either case, local and state health departments in the United States are notified of the arrival of the person to facilitate initiation or continuation of treatment.

A Class A refugee who is eligible to enter the United States must have at least 2 sputum smears, taken at least 1 day apart, that are negative for acid-fast organisms, before he or she is considered noninfectious and permitted to travel. Any form of extrapulmonary tuberculosis, as well as pulmonary tuberculosis designated Class B, is considered noninfectious for travel purposes. The medical examination form (OF-157, formerly FS-398) must specify if the individual has Class A or Class B tuberculosis, give the results of bacteriologic studies, describe X ray findings, and detail the treatment. A copy of the OF-157 and the chest X rays remain with the refugee. A copy of the OF-157 should be forwarded to the local health department along with a copy of either the "Report of Alien with Tuberculosis Waiver" (CDC 4.451) — for Class A cases — or the "Report of Alien with Tuberculosis Not Considered Active" (CDC 4.447) — for Class B

cases. A copy of the CDC 4.451 or the CDC 4.447 also should be sent to the state health department at the refugee's destination and a copy given to the refugee. Appropriate follow-up procedures then become the responsibility of the refugee and the health department.

CDC has recommended that Class A tuberculosis cases with positive bacteriology and/or cavitory lesions on chest X ray be started on treatment consisting of isoniazid (INH), rifampin, and ethambutol. Ethambutol has been included because, based on drug-resistance studies done in the United States, it is estimated that approximately 10% of the refugees with tuberculosis may be infected with an organism resistant to INH. Children too young to be assessed for alterations of visual acuity should receive INH, rifampin, and streptomycin. The doses of drugs for adults are INH, 300 mg daily; rifampin, 600 mg daily (450 mg daily for persons weighing less than 50 kg); ethambutol, 15-20 mg per kg body weight daily (the dose can be rounded off, e.g., 800 mg, 1000 mg, 1200 mg). For children the doses are INH, 10 mg per kg of body weight daily up to a maximum of 300 mg; rifampin, 10 to 20 mg per kg of body weight daily; ethambutol, 15 to 20 mg per kg of body weight daily; streptomycin, 20 mg per kg of body weight up to the maximum of 1 g daily. Class A tuberculosis cases other than those with positive bacteriology and/or cavitory lesions on chest X ray may be started on treatment at the discretion of the examining physician, or treatment may be deferred until arrival in the United States.

Follow-up and Treatment after Arrival in the United States

If treatment has not been started abroad on a refugee with Class A tuberculosis, specimens should be obtained for bacteriologic examination (smear and culture) and for drug-susceptibility tests. Depending on the examining physician's clinical judgment, treatment may be started after specimens have been obtained or deferred until the results of the tests are available. Treatment started in the United States should follow the regimens outlined above. When drug-susceptibility results are available, treatment can be adjusted accordingly. However, it is important that the regimen always contain at least 2 drugs to which the organisms are known to be, or thought to

(Please turn to page 403)

* Conditions for which a person would be excluded entry into the United States are designated as Class A by the Immigration and Naturalization Service. These are as follows: 1) syphilis, gonorrhea, chancroid, granuloma inguinale, and lymphogranuloma venereum. These conditions are not excludable if they are adequately treated. 2) active tuberculosis. 3) infectious leprosy. 4) mental retardation, insanity (past, present), and severe personality disorders, including chronic alcoholism and drug addiction. Mental retardation and previous attacks of insanity are waivable under certain circumstances, as established in the Immigration and Nationality Act.

* The 2 exceptions are Indonesia and Singapore, where only refugees 15 years of age or older are screened for tuberculosis.

(Continued from page 400)

be, susceptible. If cultures are negative, precluding drug-susceptibility testing, then INH, rifampin, and ethambutol should all be continued for the duration of therapy. Treatment should continue for a period of 12 months after sputum specimens are negative. For patients with negative bacteriology, the total period of treatment should be 12 months.

If treatment has been started abroad on a refugee with Class A tuberculosis, the refugee would have negative sputum smears before being permitted to travel. Upon arrival, treatment should be continued, but specimens should be obtained for attempted culture and drug-susceptibility tests. If the culture results are positive, proceed as above and adjust regimen, if necessary, according to the drug-susceptibility test results. If the cultures are negative, precluding drug-susceptibility testing, it is necessary to continue a regimen of INH, rifampin, and ethambutol for a period of 12 months after sputum specimens are negative.

Class B tuberculosis patients are a high-risk group and should be re-evaluated upon arrival in the United States. If "active" disease is found, indicating either incorrect classification or development of progressive disease after the initial medical examination, consider the person as a case of tuberculosis and treat as described above. If the Class B designation is correct, these refugees are candidates for preventive therapy with INH. Even though as many as 10% of Class B patients may be infected with an INH-resistant organism, it is not possible to identify these individuals. Therefore, it is recommended that INH be used for preventive therapy; if tuberculosis caused by INH-resistant organisms should develop later in any of these persons, it can be treated appropriately with other drugs at that time.

Preventive therapy is recommended for contacts of tuberculosis patients and other infected persons who may be identified. Since a positive reaction from BCG vaccination cannot be distinguished from natural infection, the tuberculin test should be interpreted without regard to BCG vaccination. INH is recommended unless the person is known to have been exposed to a source case with INH-resistant tubercle bacilli. In that situation, 1 of the following 3 alternative approaches may be selected: 1) treat with INH; 2) treat with rifampin (alone or in combination with INH or another drug); or 3) use no drugs for preven-


tive treatment but assure close clinical follow-up and provide treatment with appropriate drugs if tuberculosis develops.

Depending upon the number of refugees in the community and the resources available, health departments will have varying degrees of difficulty in accommodating the increased case load presented by Indochinese refugees. The recommended priorities for tuberculosis control in Indochinese refugees are as follows: 1) evaluation, management, and contact investigation of Class A cases; 2) evaluation, management, and contact investigation (if indicated) of Class B cases; 3) tuberculin screening and preventive therapy programs for children, e.g., testing of all refugee children entering the community's school system; 4) evaluation and follow-up of the family and other close associates of children found to be infected; and 5) tuberculin screening and preventive therapy programs for adult refugees under 35 years of age. Screening programs are not recommended for older refugees because the vast majority would not be candidates for preventive therapy. (The exception would be those with abnormal chest X rays who have already been identified as Class B patients at the time of their arrival in the United States.)

Although there is some risk of transmission of tuberculosis from refugees to the U. S. population, the current methods of detection and the use of appropriate containment procedures make the risks minimal. Efforts are being made to improve the medical evaluation of refugees overseas, including the interpretation of X-rays and performance of laboratory bacteriologic procedures, and to assure that health departments are properly notified of the arrival of refugees who have tuberculosis.

MALARIA

Malaria can be definitively diagnosed only through the careful microscopic examination of blood films. Both thick and thin blood films should be made from each patient's blood. Thick films provide the best opportunity to detect the lowest number of parasites but require some training and experience to read. Thin films are used for species identification. Blood films should be prepared from specimens from all refugees who have a fever. The films should be promptly stained (Giemsa stain preferred) and examined for parasites, and the species and approximate density of parasites (i.e., number per 100 white blood



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cells on thick films) should be noted, if possible.

Signs and symptoms other than fever that suggest the possibility of malaria also dictate a blood film examination. These would include anemia, splenomegaly, chills, headache, backache, and malaise. Negative blood films on at least 2 consecutive days aid in ruling out malaria infection. Although detectable parasitemia almost always accompanies a clinical attack of malaria, parasitemia may occur in the absence of significant symptoms.

Treatment

Presumptive Therapy: Identification of the species of *Plasmodium* should be done as soon as possible. However, presumptive therapy should be instituted to prevent serious complications and death before the diagnosis can be confirmed parasitologically. Since many refugees will be coming from areas of Southeast Asia where chloroquine-resistant *P. falciparum* malaria is endemic, presumptive antimalarial therapy for such refugees must be undertaken with the possibility of chloroquine-resistant *P. falciparum* malaria in mind. For patients who are seriously ill with the presumptive

diagnosis of *P. falciparum* malaria, parenteral or oral quinine is indicated. Parenteral quinine should be used with extreme caution and is chiefly indicated for patients who cannot take oral medication. For clinically stable patients chloroquine may be started as an alternative to quinine in initial presumptive therapy, but the patient should be kept under careful observation.

Therapy of Laboratory-Confirmed Cases: When the species has been identified, specific therapy should be instituted along the following guidelines:*

1. *P. falciparum*: Because of the high proportion of chloroquine-resistant *P. falciparum* in Southeast Asia, all *falciparum* infections seen in refugees should be assumed resistant, and one of the following regimens should be used:

a. Quinine sulfate, 650 mg, t.i.d. × 3 days, plus pyrimethamine, 25 mg, b.i.d. × 3 days, plus sulfadiazine, 500 mg, q.i.d. × 5 days; these 3 drugs must be administered concurrently.¹

b. Quinine sulfate, 650 mg, t.i.d. × 3 days, plus Bactrim Double Strength† (160 mg trimethoprim and 800 mg sulfamethoxazole), 2 tablets, b.i.d. × 5 days, administered concurrently.

c. Quinine sulfate, 650 mg, t.i.d. × 3 days, plus tetracycline, 250 mg, q.i.d. × 10 days, administered concurrently.²

Several points about the above therapy should be noted.

Sulfonamides are used in combination with a folic acid antagonist (e.g., pyrimethamine or trimethoprim) because they are synergistic. The type of sulfonamide used is not critical, provided that a sufficient blood level is maintained for at least 5 days. While combinations of sulfonamide, a folic acid antagonist, and a tetracycline are effective schizonticides, their rate of action is slow. Thus, at least 3 days of quinine therapy is important to rapidly reduce the parasite density to safe levels. Treatment of *P. falciparum* malaria is effective in up to 95% of cases; however, such patients should be carefully followed up for at least 90 days to detect recurring symptoms or parasitemia. Recurrences are usually within the first 30 days, but may occur later. Retreatment may be with the same or another drug combination.

* All chloroquine and primaquine doses are expressed in terms of the base. Dosages of all drugs are given as the adult dose. Proportional reduction in dosage would be necessary for children.

† Use of trade names does not imply endorsement by the PHS or the U. S. Department of Health, Education, and Welfare.

2. *P. vivax*: The recommended treatment for *P. vivax* infections is a total dose of 1.5 g of chloroquine (base) over a 3-day period (600 mg initial dose, followed by 300 mg at 6, 24, and 48 hours). There have been no reports of resistance of this species to chloroquine, and this regimen should eliminate the parasitemia and symptoms within 24 to 72 hours. Relapses may occur after chloroquine treatment unless radical curative therapy is administered to eliminate the exoerythrocytic schizonts in the liver. The 2 accepted regimens for radical curative therapy are as follows:

a. Primaquine, 15 mg (base) daily for 14 days. The initial dose should be in association with chloroquine, either with the normal therapeutic course, or, if administered later, with a single dose 600 mg (base) of chloroquine.

b. Primaquine, 45 mg (base) weekly for 8 weeks.

For a closely supervised patient, the 14-day regimen may be preferable because regular drug-taking would be assured and the likelihood of missing doses during the longer 8 week course of treatment would be avoided.

The administration of primaquine or chloroquine-primaquine mixtures may cause gastrointestinal symptoms in some patients. Patients with glucose-6-phosphate dehydrogenase (G6PD) deficiency may experience mild to severe hemolysis during primaquine therapy. Because an estimated 10%-12% of nationals from Southeast Asia may have at least some level of deficiency of this enzyme, it is recommended that all patients be screened for G6PD deficiency before primaquine treatment is begun and that periodic determinations of hematocrit be done during therapy. Those with a G6PD deficiency should be placed on the once-weekly dosage schedule rather than the daily regimen. The hemolysis is reversible upon cessation of the drug, and a significant and persistent fall in hematocrit should dictate cessation of treatment.

3. *P. malariae*: Most authorities believe that *P. malariae* is not a relapsing species of malaria. There are no reports of *P. malariae* resistance to chloroquine. Therefore, this species may be treated with chloroquine in the doses outlined above for *P. vivax*; no primaquine therapy is indicated.

PARASITIC INFECTIONS OTHER THAN MALARIA

Parasitic infections are common in the Indochinese refugees who are now entering the

United States. For example, a survey of 165 Laotian refugees examined in Illinois in February 1979 found hookworm to be the most common intestinal parasite in this group (64%), followed by *Giardia* (18%), *Trichuris* (12%), and *Ascaris* (9%).³ Many of these are infections with which most American physicians have had little or no experience.

Refugees infected with intestinal helminths (worms) do not pose a significant public health hazard since adequate sewage disposal interrupts transmission of the helminths, which require several days of incubation in the soil before becoming infective. Adequate hygienic practices will also minimize the risk posed by intestinal protozoa. Although CDC does not consider it necessary to screen routinely all Indochinese refugees for intestinal parasites, testing for such parasites is indicated as part of a complete examination of individual refugees requiring medical care.

Physicians who want consultation on the diagnosis or therapy of parasitic infections, including malaria, should call the Parasitic Diseases Division, Bureau of Epidemiology, CDC (404) 329-3676.

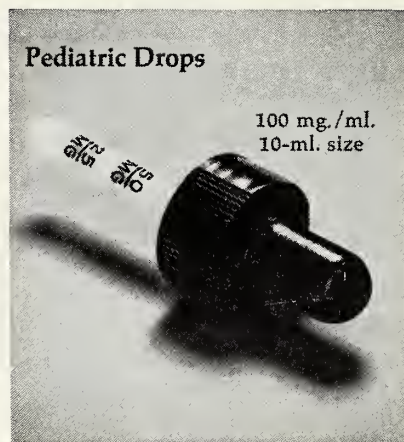
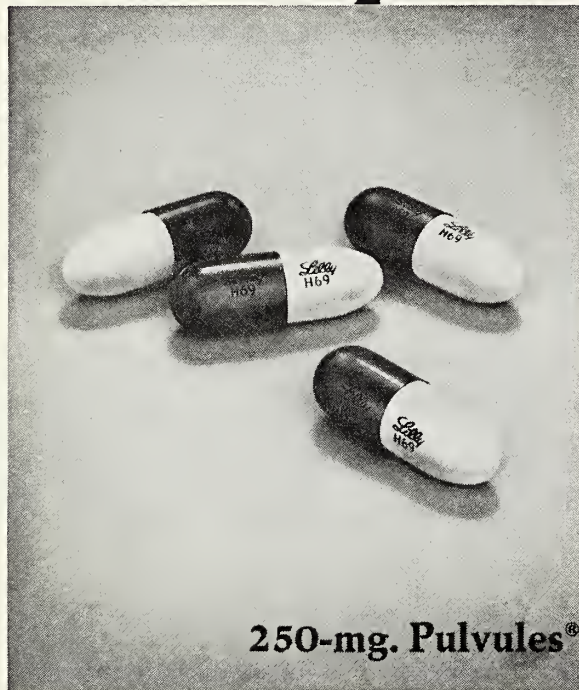
SEXUALLY TRANSMITTED DISEASES

Adult refugees receive a medical examination and a syphilis serologic test as part of routine medical screening for obtaining a visa. Patients with obvious genital infections or reactive serologic tests are referred to local health-care facilities for further evaluation and treatment before departure for the United States. Preliminary results of special studies that screened refugee groups for the presence of sexually transmitted diseases indicate that the prevalence of these diseases is very low. Upon arrival in the United States, refugees are invited to attend any PHS hospital or state or local health-care facility for full evaluation of new or pre-existing conditions.

Recommended treatment regimens for syphilis and gonorrhea have been published^{4, 5} and should be followed when treating refugees who develop a sexually transmitted disease after arrival in the United States. Although isolates of *Neisseria gonorrhoeae* from Southeast Asia may be relatively resistant to a variety of antibiotics, initial therapy should consist of procaine penicillin G, ampicillin, amoxicillin, or tetracycline in adequate doses, as recommended by CDC. Follow-up cultures 3-5 days

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(Continued from page 405)

after therapy are important to detect treatment failures caused by resistant organisms. Positive follow-up cultures should be tested for the presence of penicillinase (B-lactamase)-producing *N. gonorrhoeae*.

CHILDHOOD IMMUNIZATIONS

Refugee children who have been immunized in the camps should carry a record of such immunizations with them. Current indications are, however, that most refugee children are not receiving routine immunizations before leaving Southeast Asia. CDC is seeking to improve the immunization status of refugees before they enter the United States, but prudence dictates that all children be evaluated carefully to determine their immunization status upon arrival in the United States.

The purpose of these recommendations is to protect immigrants and persons already residing in the United States from vaccine-preventable diseases. The objective is to ensure that all immigrants receive, when appropriate, vaccines recommended for routine use in the U. S. population. These recommendations are adapted from those of the PHS Advisory Committee on Immunization Practices (ACIP).

Because of immunization requirements for U. S. public schools, all refugee children 2 months through 18 years (up to the 19th birthday) should be up to date on diphtheria, tetanus, and pertussis (DPT) vaccine or tetanus-diphtheria toxoid, adult type (Td); oral polio vaccine (OPV); and measles, mumps, and rubella (MMR) vaccinations. Girls 14 through 19 years old may be immunized with MMR vaccine if they are not pregnant and understand that they should avoid pregnancy for 3 months after the vaccine is given. Use of a standard vaccination record facilitates the recording and transfer of immunization records.

Certain vaccines can be given simultaneously without increasing the rate of adverse reactions or interfering with the immune response. Two acceptable combinations are DTP with OPV, and OPV with MMR. While the effectiveness of the combined administration of DTP and MMR is not certain, it is reasonable to give OPV, DTP, and MMR simultaneously under certain circumstances: if the individual is thought to have had no previous immunizations, if further follow-up is questionable, or if the time available to immunize the person is limited.

None of the live-virus vaccines discussed here has been associated with allergic reactions. Allergy to eggs is not a contraindication to their use. However, these vaccines should not be given to persons known to have compromised immune systems from disease or medical therapy. MMR vaccines should not be given to women known to be pregnant, and women receiving them should avoid pregnancy for 3 months after vaccination.

Previous serious reactions with DTP or Td are a contraindication to the subsequent administration of these vaccines.

Diphtheria-Tetanus-Pertussis

Children 6 weeks through 6 years of age should receive a primary series of DTP vaccine consisting of 4 doses, 3 given at 4- to 8-week intervals and a fourth given 1 year after the third. Immunization should begin at 2 to 3 months of age, if possible. A booster dose of DTP is recommended when the child is 4 to 7 years of age, usually just before entering school.

Persons 7 years of age or older who have not previously received a primary series of DTP vaccine should receive a primary series consisting of 3 doses of Td, with 2 doses 4 to 8 weeks apart and the third dose 6 to 12 months later. A routine booster of Td is recommended only every 10 years.

Persons who have received a partial series of DTP or Td vaccine can simply complete the series and be considered up to date. DTP and Td vaccine received in Southeast Asia should be considered of adequate immunogenicity for purposes of these recommendations. Unnecessary additional doses of these vaccines should not be given, since adverse reactions may occur more frequently when larger numbers of doses have been administered.

Poliomyelitis

Only persons under 19 years of age need to be vaccinated against polio. Most adults from Southeast Asia will be naturally immune if they have not already been vaccinated.

Vaccination may be completed with OPV or inactivated polio vaccine (IPV).

A primary series of OPV consists of 3 doses, 2 given 6 to 8 weeks apart and the third given 8 to 12 months later. Ideally, polio vaccination is initiated during infancy. A booster of OPV is recommended before school entry; other

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STATE DEPARTMENT OF HEALTH

(Continued from page 407)

booster doses should not be necessary for persons immigrating to the United States.

A primary series with IPV consists of 4 doses, 3 given at 4- to 8-week intervals and the fourth given 6 to 12 months later. Booster doses of IPV are recommended every 5 years. IPV is the vaccine of choice for persons with compromised immune systems since OPV is contraindicated in this situation.

Measles-Mumps-Rubella

Refugees aged 15 months to 20 years should receive a single dose of combined MMR vaccine.

LEPROSY

Leprosy has been a relatively uncommon

problem among refugees from Southeast Asia. Currently, persons diagnosed as having infectious leprosy are excluded from admission to the United States. However, persons with leprosy under appropriate treatment can be admitted and present a minimal health risk to the U. S. population. Such persons will be reported to the state and local health department in the jurisdiction to which they are destined for follow-up. Guidance on medical management can be obtained from U. S. PHS hospitals in Carville (Louisiana), San Francisco, and Staten Island, and from Leahi Hospital in Honolulu.

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ABOUT IOWA PHYSICIANS

Dr. Daniel Youngblade, Sioux City, is the 1979 recipient of the annual Key Award of the Iowa State University Siouxland Area Alumni Club. Dr. Youngblade is president of the National Cyclone Club. . . . **Dr. Preston Gibson**, Davenport, was honored recently for his 51 years in the medical profession. An engraved Golden Hour Clock commemorating the occasion was presented to Dr. Gibson by Abbott Laboratories. . . . **Dr. Robert C. Brown**, Iowa City, and **Dr. Clarence J. Ludwig**, Waterloo, recently were named fellows of the American College of Radiology. Dr. Brown received the M.D. degree at Loyola University in Chicago. He is associated with University Hospitals in Iowa City. Dr. Ludwig received the M.D. degree at Creighton University School of Medicine in Omaha and is a staff member of Schoitz

Memorial and St. Francis hospitals in Waterloo.

Dr. Ruth Langstraat, internist, and **Dr. Steven Wolfe**, family physician, plan to begin medical practice in Spencer. Dr. Langstraat received the M.D. degree at U. of I. College of Medicine and is completing her internal medicine residency at Iowa Methodist Medical Center and VA Hospital in Des Moines. She will begin her solo practice in August. Dr. Wolfe joined Spencer Medical Associates in July. A graduate of the U. of I. College of Medicine, Dr. Wolfe served his family practice residency in the Siouxland Family Practice Residency Program, which involves the St. Luke's Medical Center and the Marion Health Center in Sioux City. . . . **Dr. Robert Patterson**, Conrad physician since 1962, will relocate in Ames in mid-August where he will be associated with the Iowa State University Student Health Service. . . . **Dr. Steven Johnson** has joined **Dr. W. D. Edgerton** in the practice of obstetrics and gynecology in Davenport. Dr. Johnson received the M.D. degree and completed his residency at the U. of I. College of Medicine. Prior to locating in Davenport, Dr. Johnson

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ABOUT IOWA PHYSICIANS

(Continued from page 408)

served two years in the U. S. Air Force and a temporary Fellowship in perinatology in Louisville, Kentucky.

Dr. Steve Ellison has joined the Internal Medicine Department at the Ottumwa Clinic. A native of Waverly, Iowa, Dr. Ellison received the M.D. degree and had his internal medicine residency both at the U. of I. College of Medicine. . . . **Dr. Willard P. Marble**, Marshalltown, was honored recently for his 50 years in the medical profession. **Dr. A. J. Havlik**, Tama, presented a plaque to Dr. Marble on behalf of the physicians at the Marshalltown Area Community Hospital. Dr. Marble received the M.D. degree at the U. of I. College of Medicine and had his surgery residency at the Mayo Clinic in Rochester, Minnesota. . . . **Dr. Jim Lehman** has joined the staff at the Bluff Medical Center in Clinton. Dr. Lehman received the M.D. degree at U. of I. College of Medicine and had his internal medicine residency at the University of Nebraska School of Medicine in Omaha. . . . **Dr. Douglas Hoch** joined the Corydon Medical Clinic in July. A native of Chariton, Iowa, Dr. Hoch received the M.D. degree at U. of I. College of Medicine and had his family practice residency at Mercy and St. Luke's Hospitals in Davenport.

Dr. Thomas C. O'Neil began family practice at the Hubbard Community Medical Center in July. Dr. O'Neil is associated with the National Health Service Corps. . . . **Dr. Barry Olson** joined the anesthesiology department at Grinnell General Hospital in September. Dr. Olson received the M.D. degree at the University of Wisconsin School of Medicine and completed his anesthesiology residency at Wilford Hall Air Force Hospital, Lackland Air Force Base, Texas. He was formerly with the Gunderson Clinic in LaCrosse, Wisconsin. . . . **Drs. Romeo and Elnora Sembrano** recently began medical practice in Farmington. Dr. Romeo Sembrano received his medical education at the University of Santo Thomas, Manila, the Philippines. Prior to locating in Farmington, he practiced family medicine in Charleston, West

Virginia. Dr. Elnora Sembrano received her medical education from Far Eastern University in Manila. She is a pediatrician. . . . **Dr. Stephen Veit** began family practice in Peterson in September. Dr. Veit received the M.D. degree at U. of I. College of Medicine; interned at the United States Public Health Hospital in San Francisco and practiced with an Emergency Room Group in Oakland, California. . . . **Dr. Byron Beasley**, Mason City, was guest speaker at the August meeting of the Wright County Medical Society. Dr. Beasley spoke on new technology in cardiology.

Dr. Daniel M. Rhodes and **Dr. James E. McCabe** have joined the Buena Vista Clinic in Storm Lake. Both Dr. Rhodes and Dr. McCabe received their M.D. degrees at the U. of I. College of Medicine and completed family practice residencies in Sioux City. . . . **Dr. Ron Terrill** joined the Marshalltown Medical Clinic in August to practice internal medicine. Dr. Terrill received the M.D. degree at U. of I. College of Medicine and completed his internal medicine residency at Butterworth Hospital in Grand Rapids, Michigan. . . . **Dr. Paul Knouf** joined the McCrary-Rost Clinic in Rockwell City in August. Dr. Knouf received the M.D. degree at U. of I. College of Medicine and had a family practice residency at Iowa Lutheran Hospital in Des Moines. . . . **Dr. James P. Cafaro** has opened an office in Waterloo to practice internal medicine. Dr. Cafaro completed his residency in pulmonary medicine at the University of Wisconsin School of Medicine in June. In addition to his private medical practice, Dr. Cafaro will be medical director of the Department of Respiratory Therapy at Allen Memorial Hospital. . . . **Dr. Gene N. Herbek** has joined the Pathology Department at St. Luke's Medical Center in Sioux City. Dr. Herbek received the M.D. degree at the University of Nebraska School of Medicine and completed his residency in anatomic and clinical pathology at University of Nebraska Hospital.

Dr. Byron T. Beasley has joined Internal Medicine Associates in Mason City. From Des Moines, Dr. Beasley received the M.D. degree at U. of I. College of Medicine; interned at Indiana University School of Medicine in Indianapolis; and completed a cardiology fellowship at the U. of I. . . . **Dr. Saadi Albaghdadi**

(Please turn to page 412)

...in the functional bowel/irritable bowel syndrome*

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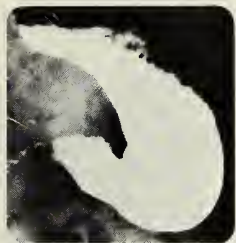
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10 mg./5 ml. syrup, 10 mg./ml. injection

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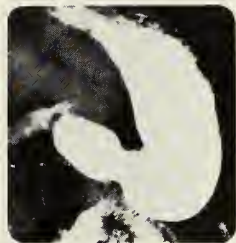
Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



Pylorospasm has almost totally blocked passage of barium meal.



Barium meal beginning to pass 10 minutes after intramuscular injection of 20 mg. Bentyl.

"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloro-duodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonfuls syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20 mg.) every four to six hours intramuscularly only. **NOT FOR INTRAVENOUS USE.** **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine[®] (bethanecol chloride USP) should be used.

Product Information as of October, 1978.

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ABOUT IOWA PHYSICIANS

(Continued from page 410)

joined Medical Associates in Clinton in August. Dr. Albaghdadi received his medical education in Bagdad; interned at St. Vincent Hospital in Erie, Pennsylvania; completed an internal medicine residency at Huron Road Hospital in Cleveland, Ohio; and recently completed two years of fellowship training in cardiology at University Hospitals in Cleveland. . . . **Dr. Natu Patel** joined **Drs. Duane Mitchell and Sudhir Marfatia** in Mount Ayr in July. Dr. Patel received his medical education in Bulsar, India, and took additional postgraduate work in England. He recently completed his surgery residency at St. Barnabas Medical Center in Livingston, New Jersey. . . . **Dr. Liem-Som Oei** has joined **Dr. George G. Spellman** in Sioux City. Dr. Oei had his medical education at the Catholic University of Leuven, Faculty of Medicine, in Belgium. He interned and served an internal medicine residency at the Academic Hospital, St. Raphael, Leuven, Belgium. His other postgraduate training has been at Brookdale Hospital Medical Center in Brooklyn, New York and a fellowship in nephrology and hypertension at University Hospitals in Iowa City.

Dr. Stanley I. Levine, Ottumwa pediatrician, was guest speaker at recent meeting of the Goldfinch Chapter, American Business Women's Association. Dr. Levine discussed child abuse and child neglect. . . . **Dr. Drew M. Sieben**, Fort Dodge urologist, was guest speaker at recent meeting of the Woodbury County Medical Society. Dr. Sieben spoke on urinary infections. . . . **Dr. Martha B. Capizzi**, Glenwood, recently won a signed limited-edition print of an original wood engraving by Barry Moser of the Greek philosopher, Plato, in Astra Pharmaceuticals' first "On Pain and Sensation" sweepstakes.

DEATHS

Dr. A. B. Kuhl, Jr., 73, Davenport, died at his home on August 13. Dr. Kuhl received the M.D. degree at U. of I. College of Medicine. He began his medical practice in Davenport in 1931 and retired in 1976. A World War II veteran, Dr. Kuhl was a staff member of Mercy Hospital and fellow of the American College of Surgeons.



PRESIDENT'S PRIVILEGE

With most physicians the term *alternate delivery system* (ADS) is nearly synonymous with *health maintenance organization* (HMO). The HMO is certainly the best known and one of the oldest contract systems of medical delivery.

The Kaiser-Permanente Health Plan was founded in 1938 by Sidney R. Garfield, M.D. (Iowa/'28). It was formed to serve workers on the Grand Coulee Dam. It has been one of the most successful examples of this type of prepaid medical care.

Heavy federal promotion of HMO's this decade has been in an effort ostensibly to control medical care costs. And while the number of HMO's has increased, most enthusiasts concede the growth has lagged behind what was anticipated.

We now see a new wave of HMO interest evolving for the 80's. A major impetus is coming from industry. The belief exists that runaway employee health care costs may be braked in this way. Medicine can expect a continuing discussion of the subject with business, labor, and government. It behooves us all to know the basic attributes of prepaid systems, if we are to negotiate intelligently with those advocating their implementation.

Financially, prepaid systems contract with or employ providers to *provide* medical services to their enrollees, instead of indemnifying the patient to *pay* for services once rendered, as is the case with conventional health insurance plans.

Comparisons of the existing fee-for-service, third-party system with the HMO frequently stop with this distinction. They fail to point out that to make prepayment economical, it is necessary to combine organization, delivery, and financing of *ambulatory* and *hospital* patient services in one total system. This is quite different from the current virtually independent status of physician, hospital, and insurer.

The doctor-patient relationship will need to be preserved if an alternate delivery system is to be accepted by patients and physicians. At least this is what most studies and surveys suggest. The Individual Practice Association (IPA) plan is intended to meet this need. It is also the least disruptive to current practice methods. One must remember, however, the most important word in the IPA is *Association*, for to improve on the economic efficiency of the status quo, the hospital, insurer, and physician must associate to function as one total system.

Paul M. Seebohm M.D.

Paul M. Seebohm, M.D.

This issue has several features of possible interest to patients. We mention the gold insert particularly. It's titled Here's to Your Good Health! We encourage you to put the Journal in your reception area when you've read it.

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Papal Crowds: Medical Challenge

JOHN H. GAY, M.D.

Des Moines, Iowa

Preparations for the Des Moines visit of Pope John Paul II on October 4 were massive. The people involved have received high praise for their efforts. Included are those who provided the emergency health coverage. Their efforts and the results are described here by the medical coordinator for the project.

IN THE PRE-DAWN CHILL we gathered, wondering silently what the day would bring. Hundreds of our volunteers — medical students, nurses, emergency medical technicians, doctors, and other professionals — were bathed in an eerie orange glow from the powerful lights above. We spoke in excited but hushed tones. The clear, angular, modern lines of the Girl Scout Headquarters outside Des Moines contrasted sharply with the rolling hills and newly mown fields of Living History Farms. Already the grey forms of thousands of pilgrims moved quietly and purposefully toward the high ground around the altar where Pope John Paul II would preach. Everywhere there was an air of immensity and expectancy.

Less than four weeks earlier a few of us began discussing plans for meeting the health needs of the crowds attracted by the visit of Pope John Paul II. The crowd would range from 250,000 to 750,000, the professional planners estimated. Over 36 linear miles would be

needed on the interstate for bus parking alone. A lengthy "extraction" of the crowd, probably lasting up to 6 hours, or around 10 p.m., was anticipated. (Military jargon of crowd "insertion" and "extraction," at first strange to our ears, became comfortable in a short time.) Many in the crowd would be sick, or elderly, or fatigued — and some people would be all of those. The event would be entirely outdoors, exposing everyone to the elements. All their physical needs — food, health, sanitation, toilets — had to be provided at the relatively isolated site, miles from downtown Des Moines. The medical logistics seemed at once to be staggering, challenging, and intriguing.

NO ROCK CONCERT

What needs would this large crowd have? Little has been written on the health needs of a large crowd such as we expected. Most articles on the subject reflected experience gained from youth rock concerts, e.g., Woodstock. However the problems of youngsters at rock concerts seemed only remotely applicable to the crowd attracted by the Pope. We had only our judgement on which to rely. We could envision two divisions of health problems among this crowd: minor trauma and life endangering situations. The minor problems (bruises, cuts, sprains, fractures, etc.) probably would outnumber the serious ones by at least ten-to-twenty-fold. The major problems would primarily be cardiac — heart attacks — but other life threatening events had to be considered also (diabetic reactions, seizures, strokes, etc.).

To handle the numerous minor problems, the Red Cross graciously consented to bring in its well-organized teams. Over the years the

Dr. Gay was medical coordinator for the visit of Pope John Paul II to Des Moines on October 4, 1979. He is a pediatric cardiologist in private practice. He has coordinated life support units at the Iowa Girls' High School Basketball Tournaments and the Drake Relays.

PAPAL CROWDS: MEDICAL CHALLENGE

Red Cross had established first aid stations at large crowd events such as the Iowa State Fair. Their past experience would bring an easy solution to the minor first aid problems of the papal crowds.

Any life threatening situation, like heart attacks with collapse, would be handled by a "life support unit" similar to ones established by the Iowa Heart Association at the Iowa Girls High School Basketball Tournament and the Drake Relays. The life support unit would be essentially a temporary coronary care unit, complete with intensive care nurses, doctors, special equipment, and medications. "Spotters" would be stationed in the midst of the crowd, constantly watching for people in difficulty. If an individual collapsed, the spotter, trained in cardiopulmonary resuscitation (CPR), would rush to the victim and quickly analyze the situation. He might need to sustain life with mouth-to-mouth ventilation and heart massage while more help arrived. The victim could then be transported back to the medical unit, possibly with CPR in progress, for further special care (I.V.'s, medications, perhaps defibrillation with electric shocks, etc.). The two "sister" units — the Red Cross first aid station and the life support unit — would be the basis for all our medical endeavors.

The medical organization relied heavily on the interactions of a number of individuals: the medical coordinator and his assistant, the chairman of the life support unit, the first aid director, a hospital liaison person, a community liaison representative, a transportation expert and a communications coordinator. A full time executive secretary proved indispensable.

40 TO 50 PHYSICIANS

In a surprisingly brief time, 40 to 50 physicians committed themselves to the project. Coronary care nurses were cautiously recruited so that hospital units would not be understaffed. Local hospitals donated equipment and supplies. A car dealer loaned seven vans. One hospital would fill one van to equip one life support unit, thereby greatly simplifying distribution and accounting. Computers were

used to contact thousands of people trained in CPR to become spotters. The College of Osteopathic Medicine and Surgery (COMS) in Des Moines not only contributed much equipment but also encouraged nearly 200 students to become spotters.

Mobile intensive care vans were donated by COMS, Creighton University, Mason City, and University Hospitals in Iowa City. The Girl Scouts loaned their large facility at the margin of Living History Farms not only to provide space for medical personnel and patients, but also to contain numerous communication gear including amateur radio equipment and direct lines to peripheral units. The Department of Public Safety loaned the use of their computer, a terminal of which was available in the Girl Scout headquarters. The list of contributors could proceed, but the reader probably would not. Therefore reluctant restraint brutalizes completeness.

That grey, cold, windy morning would have been cheerless any other day, but the date was October 4, 1979. Iowa's most historic moment was about to unfold. About 600 spotters, clad in distinctive white vests with large red hearts, were spread throughout the crowd of 350,000. Each pair of spotters had a colorful flag on an eight foot pole which would be waved to other spotters stationed at communications poles to signal any emergencies. Telephone contact from a communication pole to a peripheral medical unit would then be established. Six medical units, each serving a sector of the area, contained the first aid station and the life support unit. An identical medical unit was established also at the airport. Each medical unit had at least two ambulances parked nearby for transporting patients. Helicopters were available on several minutes' notice for air evacuation, if needed. In the event of an emergency in the crowd, emergency medical technicians (EMT'S) from the medical unit rushed with stretchers to the victim, rendering aid and transporting him back to the base.

As expected, scores of people sought out first aid at each medical unit for relatively minor problems. However, not one person collapsed with an apparent heart attack. There were no deaths. A number of people had asthmatic attacks, aggravated by the dust, cold, and windy conditions. About 50 people required transport to area hospitals for a va-

(Please turn to page 430)

THINGS YOU SHOULD KNOW

CME & LICENSURE

Iowa physicians are reminded the new continuing medical education law requires 20 hours of Category I credit each calendar year. The first Iowa CME reporting period covers 1/1/79 to 12/31/79. In April next year the Board of Medical Examiners will send a CME reporting form with license renewal applications. IMS members should keep track of their CME activity to report at that time. This is required to maintain licensure.

VETO CHIROPRACTIC RULE

Using it for the first time, Governor Ray employed his executive veto power in October to reject a proposed state agency rule to allow chiropractors to call themselves physicians. Such provision was made in rules devised by the State Board of Chiropractic Examiners. The proposed rule was regarded as contrary to Iowa statutes which specify functions of MD's, DO's, and chiropractors. The Governor indicated if a change is to be made it should be made by the General Assembly, not by the BCE.

IOWA MEDICAL HISTORY

The compilation of historical data on the first three decades (1950 to 1980) of the Iowa Medical Society's second century is a current project of the IMS Historical Committee. A pilot attempt is being made to collect pertinent historical facts via oral taped interviews with selected Iowa physicians. Time and cost will determine the extent of the project.

1979 FP FAIR

Record participation occurred in last month's Iowa Family Practice Opportunities Fair in Des Moines. The October 27 event attracted 96 family practice residents and 74 community representatives. The Fair is sponsored by the Iowa Family Practice Residents Council with cosponsorship by the U. of I. College of Medicine, the Iowa Academy of Family Physicians and the Iowa Medical Society.

MEDICAID STATUS

Implementation of the new Medicaid Management Information System is continuing at Blue Cross/Blue Shield. A high percentage of Iowa physicians now have the necessary Medicaid provider number; those still needing said number may contact the Provider Service Center at BC/BS (outside DM - 1/800-362-2218; in DM - 245-4688). Claims under MMIS are coded via CPT-IV and pre-coding is highly desirable. Computer conversion to MMIS began October 15 with refinement anticipated through the balance of this quarter.

MORE ON DISPENSING

IMS representatives met October 12 with Iowa Attorney General Tom Miller and three of his staff to reinforce a previous written request that the AG reconsider his department's opinion that physicians who dispense may not delegate the performance of this task to competent persons acting under direction as has been the custom.

IN THE NEWS

John Anderson, M.D., Boone, an Iowa delegate to the AMA, will serve on a reference committee at the interim session of the House next month...John A. May, M.D., is new assistant vice-president, medical affairs, Blue Cross/Blue Shield. Dr. May is a U. of I. medical graduate. He has been in family practice in Baldwin, Wisconsin...The IMS will host a fall meeting of the Iowa Medical Group Management Association (clinic managers) November 9 at Society Headquarters...L. W. Swanson, M.D., Mason City, IMS past-president and current secretary, became president of the North Central Medical Conference November 3/4 in Bloomington, Minnesota.



QUESTIONS - ANSWERS

ALFRED N. SMITH, M.D.
DES MOINES

COMMENTS ON THE CENTRAL IOWA HOSPICE

Dr. Smith is one of two physicians on the Board of Directors of the Central Iowa Hospice. In the private practice of surgery in Des Moines for many years, Dr. Smith is now chief of staff at the Veterans Administration Hospital.

The Central Iowa Hospice is creating considerable public interest. Would you describe its program briefly?

The Hospice of Central Iowa has developed a program to fulfill the following objectives: (1) to provide emotional, spiritual and nursing help to the terminal cancer patient; (2) to provide emotional help to the family during the terminal illness and the subsequent period of bereavement, and (3) to assist the patient's physician by carrying out the preceding supportive actions.

Where do requests for hospice assistance originate?

Requests come from the family, from the physician or from community agencies. The special care is provided by carefully selected and trained volunteers. A paid coordinator and office expenses are maintained from donations since no American Cancer Society or United Way funding has been made available.

You must be supportive of the activity as a board member. Is it something you feel doctors generally would regard as a positive enterprise?

There have been widespread misconceptions as to the role the Hospice is to play in support of medical care. By many, it has been seen as a primary provider. In actuality, its role is supportive to us as physicians as well as to the patient and family. These are the same goals of health care providers everywhere.

What are the main virtues in providing this type of program for the terminally ill patient?

The terminally ill face a mentally depressive situation and have strong need for re-evaluation of future plans. Throughout the early stages of their disease, their physicians have been their mainstays and their hope. Any lack of contributing support and encouragement adds significantly to their depression. The ability to spend their last days in the environment of home life, family, friends, etc., is very productive and reassuring if it can be accomplished. Hospice can frequently make this a reality. The subsequent reliance on Hospice may continue with family members after the death of the patient and is carried out in a progressively decreasing manner as long as it is needed. A friend-to-friend relationship is developed rather than the professional relationship which already exists between the patient, family and physician.

The CIH is a program without walls. Does it anticipate an actual structure?

A Hospice with walls is a hospital or nursing home by another name. However, ideally, it would be constructed architecturally to be more open as regards space — more home-like in atmosphere. Construction costs and staffing costs would be involved. State licensure and federal regulations would be mandated. Administrative costs would ensue. These are estimated in the present hospital setting at anywhere from 18 to 25% of total operating costs. Assuredly, JCAH regulations would also be applicable.

Our people feel in this atmosphere, the

(Please turn to page 430)

PAPAL CROWDS: MEDICAL CHALLENGE

(Continued from page 426)

riety of problems including fractured ankles, asthma, and possible heart attacks. Many found their clothes too light against the wind chill factor of 35 degrees to 40 degrees, and the supply of 300 woolen blankets was quickly exhausted. An additional 150 paper blankets from civil defense stores were trucked in. Around 200 names of lost individuals were entered into the computer. Nearly one-fourth of these names were those of children. Joyous shouts rose when the computer linked names and locations — another family reunion! However, no computer could help solve the predicament that two medical units had — overflowing portable toilets!

EXHILARATING EXPERIENCE

For most of the medical volunteers the experience of providing health care for over one-third of a million people for a day was exhilarating and humbling. The exhilaration of meeting and conquering a new challenge was doubtless felt both individually and corporately. The awesome reality of interdependence upon one another in a complex team created a sense of individual humility, appropriate for the papal visit.

The last volunteer to leave strode into the cold night air 16 hours later, too tired to talk, but not to smile.

QUESTIONS-ANSWERS

(Continued from page 428)

friend-to-friend relationship of the Hospice volunteer would suffer much. I tend to agree. Furthermore, the patient is *not* at home but is in a health center. One final factor, I feel if the patient needs to be in a health center, his/her physician is best able to decide the level of care required in the location it can be best provided.

Should there be physicians who want more information on the program, where may they inquire?

Please contact Hospice of Central Iowa, 810 Walnut, Des Moines, Iowa 50309. The telephone is 515/244-6120.

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Product Information as of September, 1977

U.S. Patent 2,985,558

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SCIENTIFIC ARTICLES

Genetic Counseling for Huntington's Disease in Iowa

JANE SIMPSON, M.S., and

HANS ZELLWEGER, M.D.

Iowa City, Iowa

"HAD WE known the illness was in the family before M._____ was born, we wouldn't have had her. I love her dearly and I am greatly perturbed about having brought her into the world to confront the hell she will go through, plus what it will do to her family."

The grief expressed in this letter from a woman whose husband died of Huntington's disease (HD) and whose daughter had just been diagnosed as having the disease is not unique. It is rather typical of the emotions expressed by affected individuals and relatives seen in genetic counseling clinics. Similar reactions are observed again and again.

HD or Huntington's chorea is a hereditary progressive disease of the central nervous system. The onset of the disease may be at any

As many as a thousand Iowans may be at a 50% risk of developing Huntington's Disease. An even larger number is at a 25% risk. The authors underscore the importance of providing accurate information to these persons. The Regional Genetic Consultation Service is available for that purpose.

time from childhood to old age, although the first symptoms most frequently appear between the ages of 25 and 45 years.

HD is transmitted by an autosomal dominant (AD) inheritance pattern. In AD conditions, affected individuals have a 50% risk of transmitting the mutant gene to each child. Both males and females may be affected. An individual who is affected at an early age may be made aware of the risk of transmitting the mutant gene to children. More often, however, individuals with HD have children before they develop symptoms and thus unknowingly transmit the mutant gene to their offspring.

SYMPTOMATOLOGY

HD is a combination of symptoms of the body, mind and personality. Any aspect of the disease may be the first to appear. The physical

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THE SCANLON MEDICAL FOUNDATION/IOWA MEDICAL SOCIETY HAS DESIGNATED THIS ARTICLE AS THE HENRY ALBERT SCIENTIFIC PRESENTATION FOR THE MONTH OF NOVEMBER 1979.

A STUDY OF HUNTINGTON'S DISEASE (HD) IN IOWA

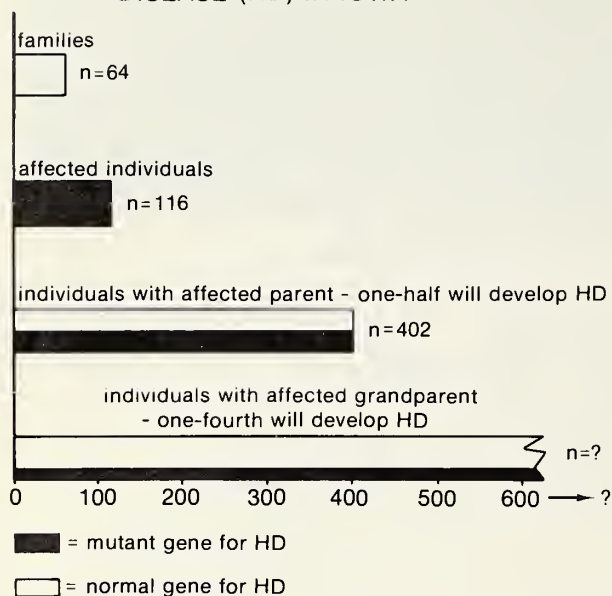


Figure 1

symptoms include nervousness, jerking, uncontrollable choreoathetoid movements of the extremities, spasms and grimaces of the face, and articulation defects. Some patients show a Parkinson-like rigidity instead of the choreatic hyperkinesia. Mental and personality changes include loss of long term and immediate memory, emotional instability associated with irritability, irascibility, violent temper and hysteria or even psychosis-like reactions. Patients, in whom mental symptoms are not accompanied by alterations in the motor system, may be misdiagnosed as having hysteria or psychosis. The progressive physical and mental deterioration may precipitate depression. Suicide and divorce rates are increased. The duration of the disease is often 10 to 20 years. In the end phases these patients are helpless and totally dependent. Admission to a well-equipped care center is inevitable.

Huntington's disease is a tragic experience for the family. It is also a burden to society both because of the need to support patients at public expense in mental health institutions, nursing homes or chronic disease hospitals for a number of years, and because of society's involvement in the social issues which result from the instability of family life, such as placement of children in foster care.

IOWA HD PICTURE

How many individuals in Iowa are affected with HD? This question is important in the provision of genetic counseling to individuals who are at risk of developing the disease or of transmitting the mutant gene to their children. A renewed attempt has been made to study Iowa families in which some member or members have HD. The Regional Genetic Consultation Service has reviewed the histories of 64 families with whom we had had contact over the past 15 years. The information is incomplete for several reasons, such as: 1) most of the families are from eastern Iowa; there is probably a comparable number of families in the Des Moines area and in western Iowa; 2) in earlier years, family counseling was not considered important, and information concerning families was not obtained; 3) some families have not been seen for several years; therefore, our information may not be up-to-date. Even with these inadequacies, the study is striking and sobering.

In the 64 families there are 116 affected individuals who are probably living now (range: zero to 10 in one large family). There are, in these 64 families, 402 non-affected individuals who have an affected parent and who are thus at 50% risk of developing the disease. In other words, half (or about 200) of the 402 persons will develop HD. If all families in Iowa were ascertained, one might estimate the number in both the affected and children-of-affected categories should be at least doubled; consequently, there might in reality be as many as 800 to 1,000 Iowans at a risk of 50% of developing HD. In addition, there is an even larger number of individuals who are at a 25% risk of developing HD because of having an affected grandparent. The family information is too incomplete to give a reasonable estimate of that number, yet one-fourth of individuals with an affected grandparent will develop HD.

These data correspond quite well with the national prevalence estimate of 1 affected per 4,000 individuals. HD figures with myotonic dystrophy and neurofibromatosis are among the most frequent autosomal dominant diseases.

GENETIC COUNSELING

In view of the severity of the disease and its high incidence, geneticists are deeply con-

cerned with HD. Genetic counseling should be available to members of HD families.

The Commission for the Control of Huntington's Disease and Its Consequences has in its report of 1977, a chapter on genetic counseling which included this statement: "The importance of good genetic counseling cannot be overestimated. Only through knowledge can individuals make an informed choice about major life decisions." The report also says: "Although the Commission is concerned with reducing the incidence of the disease in the population, the role for genetic counselors which the Commission envisions does not include prescribing the decisions HD families should make."

The authors agree with this view of genetic counseling. The purpose of counseling is to enable an individual to make an informed choice. As genetic counselors, at no time do we try to force our views on others, although we

personally believe that any individual who has a parent or grandparent with HD should not reproduce. It would seem, in a time when the stresses of life are constantly increasing and when medical care costs are skyrocketing, that HD families as well as society as a whole would benefit from this approach.

SERVICE AVAILABLE

To make genetic counseling available to all Iowans, the Regional Genetic Consultation Service (RGCS) of the Iowa State Department of Health has established a network of genetic counseling clinics in 15 Iowa cities. Counseling at RGCS Clinics is free of charge to Iowa residents. Members of HD families are invited to the clinics to ask questions and to discuss their concerns with a team of genetic counselors. Physicians and other health professionals may refer "at-risk" relatives of HD patients to the RGCS clinics by calling 319-356-2674.

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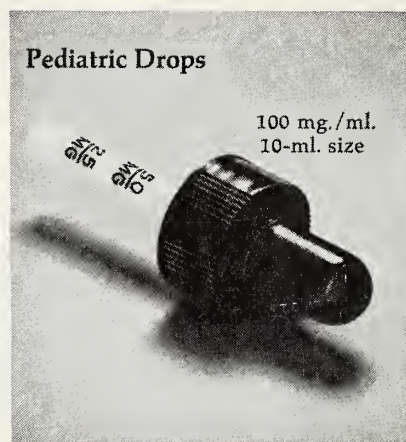
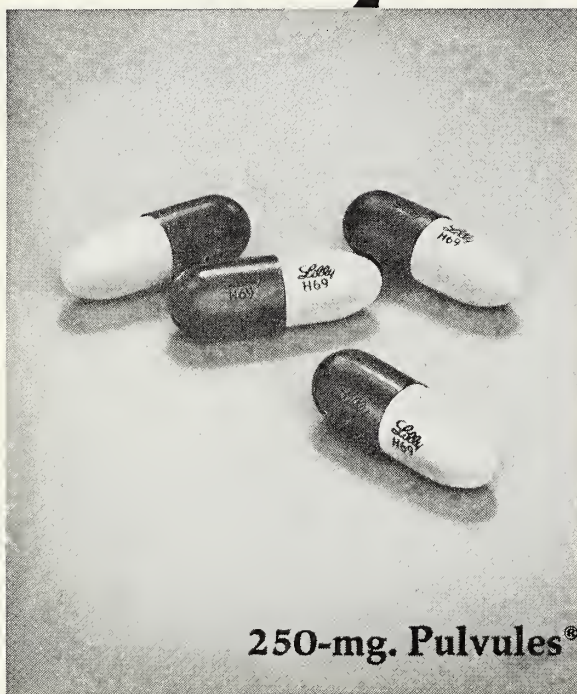
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Iowa's Commitment Law— Its Demographic and Dispositional Variables in Linn County

R. PAUL PENNINGROTH, M.D.,
KATHLEEN COEN BUCKWALTER, R.N., M.A., and
MERLE D. FISHEL, J.D.
Cedar Rapids, Iowa

This report offers statistical highlights on patients undergoing emergency and involuntary care in Linn County over a one-year period. The conclusion is offered that Iowa's new commitment law is protecting patient rights and allowing compassionate care.

ON JANUARY 1, 1976, a new Iowa commitment law went into effect. Little subsequent effort has been made to examine the attributes, experiences and outcomes of persons undergoing involuntary hospitalization procedures to see if judicial proceedings are following the intent of the new law. In other words, has commitment been justified. As a consequence, a study was undertaken by the authors to compare demographic and dispositional variables for persons involved in involuntary and emergency hospitalization procedures in Linn County from July 1, 1976 to June 30, 1977. The first part of this article pertains to demographic, admission and diagnostic variables. The second section deals with hearing results and dispositional variables. The relationship between diagnosis and case dismissal is also discussed.

Based on our interpretation of the Iowa Code, three categories were identified as a means of classifying all case records. Data sheets adapted to these commitment categories were completed for each of the 222

cases examined. Categorical breakdown of patients was as follows:

145 "Involuntary Only" — *Patients who had applications for involuntary hospitalization filed against them with the Clerk of Court by two or more interested persons, stating their belief that the respondent was seriously mentally impaired.*

47 "Emergency Only" — *Patients admitted under Section 229.22 of the Code of Iowa "Emergency Procedures."*

30 "Emergency & Involuntary" — *Patients admitted under emergency procedure who subsequently had papers filed against them for involuntary hospitalization.*

Hearings to restore competency (Section 229.27) and voluntary admissions were excluded from this study as were the cases of Linn County residents who sought voluntary treatment at the Independence Mental Health Institute for substance abuse and then attempted to sign out Against Medical Advice (Chapter 125.9 of the Code of Iowa).

FINDINGS — Demographic, Admission and Diagnostic Variables

The demographic characteristics of patients are presented in Table 1. The average age of patients was highest in the "Involuntary Only" category. No one was over 55 years of age in

Dr. Penningroth is acting medical director of the Linn County Mental Health Center and is in the private practice of psychiatry. Ms. Buckwalter is a research assistant for the LCMHC. Mr. Fishel was a judicial referee in Linn County.

either the "Emergency Only" or "Emergency and Involuntary" categories, while more than 15% of persons in the "Involuntary Only" classification were between the ages of 56 and 90. This age difference can best be explained by the number of elderly patients with senility-based organic brain syndromes in the "Involuntary Only" category. Full-time employment was greatest among persons who came in under "Emergency Only" procedures. The number of retired persons and those too im-

paired to undertake employment was highest among "Involuntary Only" subjects.

Most "Emergency" and "Emergency and Involuntary" admissions took place in the evening hours although a large percentage of "Emergency Only" patients were admitted to the hospital after midnight. The majority of persons seen under emergency procedures between the hours of midnight and 8 a.m. had a diagnosis related to substance abuse. (See Table II.)

TABLE I
DEMOGRAPHIC CHARACTERISTICS OF PATIENTS

	Involuntary Only N = 145	Emergency Only N = 47	Emergency & Involuntary N = 30
SEX			
Male	63.4%	51%	56.6%
Female	36.6%	49%	43.3%
EDUCATIONAL LEVEL			
College graduate	1.4%	0	6.6%
Partial college	16.5%	19.15%	19.9%
H.S. graduate	27.5%	36.2%	30.0%
Partial H.S.	39.3%	31.9%	33.3%
Less than 7 yrs. school	3.4%	2.1%	3.3%
Student	.69%	2.1%	—
Info. N/A	11.0%	8.5%	6.6%
MARITAL STATUS*			
Single	43.4%	36.2%	43.3%
Married	23.3%	38.3%	33.3%
Divorced	17.9%	12.7%	3.3%
Widowed	8.3%	0	0
Separated	6.9%	8.5%	20.0%
Info. N/A	0	4.2%	—
AGE			
Mean average	34.3 yrs.	27.4 yrs.	28.5 yrs.
Range	11-90 yrs.	11-55 yrs.	11-55 yrs.
OCCUPATIONAL STATUS*			
Full-time	15.8%	27.6%	20.0%
Part-time	.69%	6.4%	6.6%
Housewife	9.65%	10.6%	16.6%
Unemployed	28.9%	31.9%	29.9%
Impaired	28.2%	8.4%	10.0%
Student	6.9%	10.6%	16.6%
Retired	9.65%	0	0
Other	0	2.1%	0
FAMILY INCOME	Avg. = \$5,655	Avg. = \$5,625	Avg. = \$6,833.33
MEDICAL INSURANCE*			
None	41.5%	27.7%	23.3%
Medicare/Medicaid	26.2%	34.0%	19.9%
Commercial	27.6%	31.9%	46.6%
Other	.69%	0	3.3%
Info. N/A	1.3%	6.4%	0
Two of above	2.7%	0	6.6%

* χ^2 $p < .01$

Non-family members, police and community agencies were a frequent source of referral for persons undergoing emergency procedures. Nearly one-third of the referrals for the "Emergency and Involuntary" patients came from police and community agencies. However, when these persons had papers filed against them to undergo involuntary hospitalization procedures, it was predominantly family members who signed. Similarly, family members filed over 83% of the applications for involuntary hospitalization in the "Involuntary Only" category. Community agencies, police and non-family members played a relatively insignificant role in referral for this group.

Table II displays diagnostic breakdown according to our research categories. Many patients in this study were admitted to the hospital with multiple diagnoses, such as (1) Antisocial Personality with (2) Secondary Depression and (3) Drug Overdose. Forty-two individuals also carried a label related to acute substance abuse at the time of admission in addition to their major problem. However, for purposes of this study, only primary diagnoses have been reported. Of interest is that over 35% of all patients placed under the "Emergency and Involuntary" category had major affective disorders. One-fourth of the total in this group had a diagnosis of Bipolar Affective Disorder, Manic. There were also a significantly large number (21.4%) of persons with a diagnosis of Neurosis, many of whom were Depressive Reactions acquiring this label following a suicide attempt. Every individual falling under the "Emergency and Involuntary" category was given a psychiatric diagnosis.

The majority (37.1%) of persons falling under "Emergency Only" procedures had diagnoses related to alcohol or drug abuse. A considerable number (16.3%) carried a primary diagnosis of Personality Disorder. Under "Other" were included diagnoses such as Situational Adjustment Reactions, Panic or Anxiety States, Marital Discord and Mental Retardation.

The "Involuntary Only" category is distinguished by the number of persons with typically more chronic and incapacitating disorders such as Organic Brain Syndromes and Schizophrenias. A high incidence of Major Affective Disorders are found within this category as well. Interestingly, 6.2% of the respondents in

TABLE II
DIAGNOSTIC BREAKDOWN BY COMMITMENT CATEGORY*

Diagnosis	Involuntary	Emergency Only	Emergency Involuntary
Organic Brain Syndrome (associated with senility)	10.1%	0	3.5%
Personality disorders	11.7%	16.3%	0
Schizophrenias	21.1%	4.6%	14.3%
Neuroses	6.2%	13.9%	21.4%
Major affective disorders	23.3%	4.6%	35.5%
Alcoholism and/or drug abuse	7.7%	37.1%	10.5%
Adolescent behavior disorder	4.75%	4.6%	10.7%
Others	8.5%	13.8%	3.5%
None	6.2%	4.6%	0

*Diagnostic clarity and standardization has been contaminated by the number of psychiatrists represented in this study, many of whom use different diagnostic criteria.

this category were evaluated as having no psychiatric diagnosis.

FINDINGS — Hearing Results and Dispositional Variables

The first part of this discussion will be limited to cases in the "Involuntary Only" category, that is, those individuals who had applications filed with the Clerk of the District Court by two or more interested persons stating their belief the respondent was seriously mentally impaired. Nine of the 145 cases in this category were dismissed prior to hearing. Reasons given for the dismissals include failure of informant to show, application withdrawn, and patient never located. Twenty-two persons were not hospitalized before their hearing. These persons were either in jail, in residence at the Linn County Care Facility or local nursing homes, or were patients at the Linn County Psychiatric Unit, an intermediate care facility. All persons against whom applications for involuntary hospitalization were originally filed had hearings held within 5 days of admission. Given the criteria for this procedure (see Sections 229.6 to 229.11 of the Code of Iowa), a significantly large percentage (16.9%) had their cases dismissed by the judicial referee at hearing. The largest proportion of respondents (79.4%) were deemed mentally impaired to the extent that further inpatient treatment was warranted. Nearly one-third (30.5%) of those for whom hospitalization was ordered remained at St. Luke's Hospital with an average

(Please turn to page 440)

IMS MEMBER PHYSICIANS — The adjacent 4-page Family Medical Record is available for distribution to patients. You may obtain more (at \$2 per 100 to cover printing costs) by directing a request to Society Headquarters. Additional single copies are available at no cost.



length of stay of 21 days. Following discharge from St. Luke's Hospital, nearly as many (36.3%) were involuntarily placed on outpatient supervision as accepted outpatient treatment voluntarily (39.4%). A significant percentage of the patients requiring further hospitalization (69.4%) were ordered transferred to other facilities after their hearing. Reasons for transfer ranged from lack of insurance to obtaining further evaluations and long-term treatment. Those transferred because treatment was not available at St. Luke's Hospital were most often sent to drug and alcohol abuse programs. Several of the patients in this category were transferred to other facilities for multiple reasons. When transfer to another facility was ordered, it was accomplished swiftly with an average length of stay at St. Luke's Hospital prior to transfer of 5.5 days. The Independence MHI and the Linn County Psychiatric Unit were primarily recipients of patients in this category and together they accounted for nearly 70% of all transfers.

The following discussion pertains to the outcomes of patients admitted under emergency procedures who later had applications for involuntary hospitalization filed against them. Nearly all the patients in this "Emergency and Involuntary" category (90%) had applications signed to detain them in the hospital or other care facility. Only one case was dismissed prior to hearing. Most patients in this group (89.6%) were ordered to continue inpatient treatment. Of these, over half remained at St. Luke's Hospital. The length of stay closely paralleled that of patients in the "Involuntary Only" category, averaging 23 days. No outpatient commitment was ordered for persons in this group. A significant number (20% of these patients required no further care following hospitalization at St. Luke's although a large percentage (60%) obtained outpatient followup voluntarily. Those requiring further hospitalization (42.3%) were ordered transferred to other facilities. The Mental Health Institute at Independence received most of these patients. The primary reason for transfer was to obtain

further evaluation and treatment. Once again, length of stay at St. Luke's Hospital prior to transfer was brief, averaging one week for patients in this group.

The outcomes of persons undergoing emergency hospitalization procedures will be discussed next. Emergency procedures are authorized only when immediate detention is required and access to the district court is not available. Approximately 60% of all patients in the "Emergency Only" category were discharged from the hospital following 48-hour hold. No one was detained involuntarily for more than 96 hours as prescribed by law (See Section 229.22, Code of Iowa). In fact, the majority of patients remained hospitalized less than 48 hours. Following discharge or dismissal, 30% of the persons having been admitted under emergency procedures required no further care. An equal number sought voluntary outpatient treatment at the Linn County Psychiatric Clinic. This is best explained by the fact that acute episodes of alcohol and drug abuse were prevalent among persons in this group, problems that were likely to resolve during brief hospitalization. Referral to community agencies such as the Citizens Committee on Alcoholism and Alcoholics Anonymous were correspondingly highest in this category and were clearly related to diagnosis at the time of admission. A surprising 27.6% of the "Emergency Only" patients remained voluntarily hospitalized at St. Luke's. It is of interest the length of inpatient stay for persons in this group was significantly shorter than for persons continuing inpatient treatment in the other categories. Patients in the "Emergency Only" category stayed an average of 12.7 days at St. Luke's Hospital. This average was skewed upward by one patient who remained hospitalized for 78 days. If her case is deleted from this group, the average length of stay at St. Luke's Hospital for these voluntary patients was only 7.3 days. Of those who chose to remain hospitalized, nearly 77% sought outpa-

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tient treatment at the Linn County Psychiatric Clinic following discharge. Some patients had multiple dispositions after hospitalization, for example, both outpatient care and an agency referral, although only the primary disposition was considered for purposes of this article.

We identified the primary diagnoses of those 23 patients undergoing involuntary hospitalization procedures initially, who had their cases dismissed by the judicial referee. A high proportion of personality disorders and less severe impairments in general were noted among the group.

Seven of these 23 patients were determined to have no psychiatric diagnosis and it is appropriate their cases were dismissed. One case, with a diagnosis of "Psychosis with Paranoid Delusions" stands out among those dismissed. Detailed examination of the court record, however, reveals that the judicial referee was obligated to dismiss this case because the physicians in charge were not available for cross-examination at the hearing.

The diagnoses of patients who came in under emergency procedures and were later discharged were also recorded. A large number of diagnoses related to alcohol abuse and depressive reactions appear in this group, problems that do not necessarily require long-term hospitalization.

Three cases — chronic paranoid schizophrenia, chronic undifferentiated schizophrenia, schizoaffective schizophrenia — appear atypical within this group and one might question the wisdom of discharging patients with these diagnoses. However, the judicial referee who ruled on these cases indicated they represented temporary exacerbations of illness in "long-time patients." All three patients were discharged to the care of capable family members and personal physicians who had successfully managed their outpatient care for many years.

In looking at the diagnoses of the 13 patients in this category who voluntarily remained in the hospital for treatment, one is struck by the number of cases with multiple diagnoses. Perhaps these persons elected to continue inpatient treatment in an effort to work out multiple problems not easily resolved by a brief hospitalization.

The findings associated with demographic and admission variables were somewhat dif-

ferent from what was expected prior to undertaking this project. The original hypothesis was that most persons coming to the hospital under emergency procedures would do so on weekends and holidays. This hypothesis was not substantiated — most admissions occurred Monday through Friday inclusive. We were also surprised by the number of persons undergoing involuntary hospitalization who had a diagnostic label of organic brain syndrome associated with senility. Elderly persons suffering from senility are not generally regarded as dangerous to themselves or to others in the traditional sense. However, the "danger" for this group is one of neglect based on an inability to adequately care for themselves. The families of these elderly patients are using the new commitment law to ensure transfer to nursing homes or other care facilities. In contrast to this older age group were the large number of young people — as young as 11 years of age — who were also admitted under this law.

Our results suggest that most persons who were committed did in fact need hospitalization. Persons coming in under involuntary procedures carried diagnostic labels indicative of more chronic unremitting illnesses such as the schizophrenias. The new Iowa law provides emergency commitment procedures for persons likely to "injure themselves or others" if not immediately detained. Well over one-third of the persons in our study admitted under this provision carried a diagnosis related to substance abuse — problems requiring only short-term commitment for the most part. Moreover, their diagnoses were suggestive of more disruptive acts attracting police attention than the diagnoses of patients in the involuntary hospitalization category. Spouses played an active role in initiating hospitalization for patients in both types of commitment procedures. This finding supports the contention that partners of mental patients tend to see hospitalization as necessary and are willing to initiate commitment procedures to bring it about.

Findings related to hearing results and dispositional variables suggest the way emergency and involuntary hospitalization cases are being handled in Linn County is in keeping with the intent of the new Iowa commitment law. We believe that involuntary hospitalization is not the damaging, arbitrary and capricious

cious process it is often accused of being. The findings indicate the rights and privileges of mental patients are being protected. Persons with serious mental impairments are receiving needed inpatient treatment; the cases of persons with no psychiatric diagnosis are being dismissed. Hearings are held within the prescribed period of time and the judicial referee seems responsive to individual treatment and referral needs. When hospitalization is ordered, the average length of inpatient stay is short and most patients are treated and return to their own community. There is no evidence of patients becoming chronically institutionalized. Court-ordered treatment on an outpatient basis, intended to reduce recidivism rates, is being utilized and "Section 27" cases are being dealt with separately as mandated by law.

We originally hypothesized the majority of patients requiring hospitalization would be forced to leave Linn County for treatment because of lack of insurance coverage and the fact that the county will pay for no more than 5 days' stay at St. Luke's Hospital. Most patients surprisingly remained in Linn County. Only 38.2% of persons coming in under involuntary

procedures and 42.3% of those admitted under emergency procedures were ordered transferred out-of-county. Further evaluation and treatment, rather than insurance problems, were the primary reasons for changing facilities. And, as noted previously, transfers to other facilities were accomplished without undue delay.

SUMMARY

A retrospective study was conducted of patients undergoing emergency and involuntary hospitalization in Linn County over a one-year period. The study revealed the law is affecting a broad spectrum of individuals . . . from the very young to the very old . . . from a variety of backgrounds . . . with a wide range of mental disorders.

Findings further suggest that type of commitment is related to the nature of the psychiatric disorder, and dispositions at judicial hearings are in keeping with the severity of diagnosis. With regard to the new commitment law in Iowa, it is concluded that patients' civil rights are being protected and their right to treatment compassionately respected.


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COMMENTING EDITORIALLY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

THE POPE VISITS IOWA

This issue of the JOURNAL presents an interesting report by Dr. John Gay on the medical challenges associated with the recent Iowa visit of Pope John Paul II. The monumental task assumed by many people on short notice attests to the resourcefulness of Iowa citizens. The comments we read and hear carry high praise for the entire undertaking.

There is another view I consider germane at this time. The human reactions to this momentous visit were most revealing. We know that human reactions and emotions can

swing in many directions when thousands of people assemble in one place. In this instance, people were not seeking sensuous stimulation as from a "rock festival." The people who gathered at the airport, St. Patrick's Church, and the Living History Farms were motivated by a spiritual need. Catholics, Jews, Protestants, and other faiths alike gathered for spiritual uplift, or at least to witness such an experience. The large number of people, many of whom arrived the previous evening and in the early morning hours, waited patiently and in a well-mannered way. Hawkers of food and drink and souvenirs were disappointed. The reverence of the occasion was obvious; it was not to be a circus. Once those who arrived found a place close to the altar, they were not to leave again to lose their vantage point.

The manner of 340,000 persons was amazing. Politeness and consideration and kindness seemed to be the order-of-the-day. Children played happily, adults walked about quietly or talked amiably with their friends; the hush that fell over the hills of Living History Farms when the helicopter transporting the Pope and his entourage landed was awe-inspiring. Everyone stood quietly awaiting the appearance of Pope John Paul II. Then, there was a tumultuous welcome with music and singing. The tranquility of the hills was overwhelmed by joy and celebration. It was a good experience. I am pleased I attended; I'm sure all the others had the same satisfaction. — M.E.A.

STATE OF THE UNION

A new way of life is emerging. A new state of the union of marriage is becoming more evident. Nay, there are two forms of the state of the union of marriage, and they are diametrically opposed. Yet, I wonder if at a future time, be it a few years or several decades, one shall become like the other. That possibility is a concern to me because I have become more involved with one form than the other. Now, you ask, what is he getting at?

Mothers-to-be used to enter a hospital delivery suite at the termination of gestation to be

delivered of offspring. The father remained in an adjacent room to await the good word from the physician-in-charge. Then the infant was carried to the nursery, the mother taken to her room, and the father went home. Now, the entire gestation period, with the emergence of the newborn, has become an entirely different experience for all concerned. There are prenatal classes for the parents-to-be; they learn together the processes of labor and birth. The father becomes an integral part of the entire affair. When the magic moment arrives the participants gather in the birthing rooms. At some hospitals older brothers or sisters may be present as well. Various rituals may ensue, ac-

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EDITORIALS

STATE OF THE UNION

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cording to the practices of the physician-in-charge — lower light intensity, warm bathing of the infant, the process of bonding, and immediate placing of the infant at breast. Then from the birthing room the family may gather in a hospital room not unlike a conventional home bedroom, where the father may stay with the mother and infant. All this supports a close communion of the mother, father and child.

The other state of the marriage union to become quite prevalent is the contract affair where the man and woman are more-or-less free agents. Each may be employed outside the home, have separate bank accounts, their own possessions of household nature, a more free or unrestricted life pattern. The rate of divorce is high in present day society, both in the newer marriages, as well as marriages of a number of years. Marriages of the past were in

the majority " 'til death do us part." The family was a patriarchy. The father earned the money for the support, the mother ran the household and raised the children, and the children were expected to lend assistance as directed. Discipline, the obedience to life, was strict.

My concern is this: Will the natural state of the male once more emerge? Will men review their change of status and rebel against the equality that now prevails? Will the equal rights movement reach a point where man will wonder if he has lost his gender, his previous state of the union, his "macho"?

Let me quickly say these questions in no way indicate or imply that I am inciting a rebellion. I hope fathers will become more involved with the care of their children, that marriages will become stronger, that family life will be kindled anew. The growth of the children depends greatly on the stability of the parents. Yet, I am a realist enough to know the pendulum swings in two directions, and humans are fickle creatures. We must face the realities of life and measure each innovation with mature and open minds, hopefully the best will prevail. Time will tell. — M.E.A.

IN-STATE MEDICAL MEETINGS

Nov. 14	Update on Thyroid Disorders — Sponsor: Mercy Hospital Medical Center — Des Moines
Nov. 14	Medical Genetics — Sponsor: U. of I. College of Medicine — Holiday Inn — Burlington
Nov. 15-16	The Healthy Family, Assessment and Intervention — Sponsor: Iowa — Illinois Association for Marriage and Family Therapy — Amana Colonies — Amana
Dec. 5	Vascular Disorders of the Eye — St. Joseph Mercy Hospital — Mason City — Sponsors: St. Joseph Mercy Hospital and U. of I. Department of Family Practice
Dec. 14	Epilepsy — St. Joseph Mercy Hospital, Mason City — Sponsors: St. Joseph Mercy Hospital and U. of I. College of Medicine

The following postgraduate courses and conferences will occur at U. of I. College of Medicine in Iowa City

Nov. 5-9	Intensive Course in Pediatric Nutrition
Nov. 5-9	Aesthetic Facial Surgery
Nov. 8-10	Psychiatry Postgraduate Conference
Nov. 13-14	Postgraduate Conference on Obstetrics and Gynecology
Nov. 16	Fifth Annual Childhood Cancer Workshop
Nov. 30	Radiation Therapy Seminar
Nov. 30-Dec. 1	Otolaryngology Clinical Conference
Dec. 3-6	Cardiology Today
Dec. 5	Emergency Procedures for Physicians
Dec. 5	Ophthalmology Clinical Conference
Dec. 10-11	American College of Physicians — Medical Knowledge Self Assessment Program
Dec. 27	Radiation Therapy Seminar



OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

MOB AND MIND

In a speech recently presented* to a group of his fellow deans, Dr. Dan Tosteson of Harvard provided a clear and persuasive view of medicine as a discipline of continued learning. He means much more by that than simply an effort at CME in the usual sense. He envisions medical *practice* as a series of learning *opportunities*; each doctor-patient interaction provides an experience in learning, in the problem-solving mode, for both patient and doctor. Undergraduate and graduate medical education, then, is to prepare students to be life-long learners. (Music to my ears, of course.)

Dr. Tosteson further urges medical education to recognize increasingly that the doctor-patient interaction, to be totally effective, almost always requires a perception of the patient not only as an intricate biochemical machine, but also as a member of an interlocking mesh of relationships with other human beings, and finally, as "an individual person alone in a universe of vast complexity." This view obliges an effective physician to be able to

deal in an enlightened as well as compassionate manner with biomedical science, society, and the individual human mind/soul. Correspondingly then, the physician must have educational preparation in biomedical science, social science, and the humanities.

Treating "the whole patient" (often distorted and re-spelled these days as "holistic medicine") is not really such a new idea. But the last several years have seen a growing spirit of reaction against those spectacular scientific and technological advances from 1945-75 which gave rise to a generation of physicians and educators richly imbued with an inordinate awe of biomedical science. If, however, we truly care about health and disease, we must know more about society and what affects it (e.g., poverty, or gun-control legislation) and more about the human spirit and what affects it (e.g., values, loyalty, personal convictions of the good life).

I remember when I first saw a child nearly dead of starvation. It was in Latin America. My physician host said, "In this country we doctors think health is related to poverty and that arises largely from political decisions. I have never understood why the doctors in the USA do not seem to pay any attention to the politics of health." Perhaps we do now, more than then. But many of us still look upon medical practice largely in terms of manipulating a marvelous biochemical machine gotten out-of-whack, and too little do we look to the dependence of that machine on its milieu of mob and mind (society and personality).

Have you ever considered (1) what part of your labor, and your patients' problems arise from mob and mind, and (2) what sort of CME is appropriate to equip you better to deal with those problems? Were you to do so, you might plunge yourself into a threatening but exciting kind of study that would rouse your spirit and invigorate your monotonous routines. For such CME you might have to turn to new purveyors — most medical institutions wouldn't be able to serve your needs.

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

* Learning in Medicine, NEJM, 301:690-694, Sept. 27, 1979.

MEMBER DIRECTORY OUT

The 1979-80 Iowa Medical Society Member Directory has been distributed to member physicians recently. In addition, the Directory,

which contains alphabetical and geographical listings of member physicians, is being provided for reference use to Iowa hospitals, libraries, chambers of commerce, etc. For the first time, physician telephone numbers are shown where they have been provided.

STATE DEPARTMENT/ PUBLIC HEALTH

A DIVERSE ORGANIZATION

The Iowa State Department of Health is a many faceted organization with programs aimed at helping people. It is divided into various major divisions.

COMMUNITY HEALTH

The Division of Community Health works closely with local boards of health to furnish effective public health services at the county or community levels.

Public health nursing is a major local service component. These nurses visit homes, schools and clinics to aid people with health needs — regardless of financial standing. State personnel help implement public health nursing programs at the local level, sponsor continuing education workshops for public health nurses, administer a program of home health care and help to establish well elderly clinics.

Deaf services is another ISDH activity. Help is available to the state's 184,000 deaf or hearing impaired individuals — regardless of age or ability. Interpreters assist in medical, legal, business and personal situations. Staff members also act as advocates for the deaf community with existing public and private agencies, organizations and professional people.

The Emergency Medical Services section aims to save lives and reduce the number of highway injuries. It provides training programs for emergency medical personnel to assure Iowa citizens are cared for by qualified persons. It also coordinates the delivery of emergency services across the state.

The Renal Disease program offers financial

assistance to patients who require kidney transplants or dialysis and cannot afford this expensive long-term medical care. Since high blood pressure is a major contributor to renal disease, the Hypertension Program exists to focus attention on high blood pressure, to promote screening and better adherence to treatment.

DISEASE PREVENTION

Preventing and monitoring disease is the major responsibility of several functional units within the Division of Disease Prevention. Measles, mumps, hepatitis, gonorrhea and rabies are among the 45 infectious diseases over which surveillance is maintained. The occurrence of each disease is evaluated and control programs are developed to reduce the risk of transmission and cost to the public.

The Immunization Section maintains school based surveillance over vaccine preventable diseases. Information on vaccination issues is provided to physicians and medical clinics. To control communicable diseases, the Department administers a state law requiring children to receive minimal vaccination before they are admitted to school or to a day care center. The division also supports immunization programs by assisting at emergency vaccination clinics, by supplying vaccine and by informing the public about the importance of immunizations.

The Tuberculosis Section maintains a case registry of all active TB cases. It monitors the adequacy of treatment and assures that close contacts are screened for infection. Drugs are provided to treat active cases and exposed contacts. Efforts here, coupled with the high standard of living, have produced one of the lowest tuberculosis incidence rates among the states.

Control of venereal disease is a function of the VD Program. This is now referred to as sexually transmitted disease (STD). The Venereal Disease Section receives reports of active cases, provides confidential follow-up contacts, arranges necessary laboratory tests and assures that exposed persons receive prompt treatment. In addition, the program distributes public informational material on STD detection and prevention.

The Epidemiology Section is organized to monitor and investigate the cause and source of disease. This is done to control and prevent future cases. It involves the systematic study of

disease outbreaks and analysis of individual case data. Formal monitoring of disease has a positive impact on food product sanitation, drinking water treatment and childhood vaccination.

The Health Engineering Section enforces sanitation programs including inspection of mobile home parts, migrant labor camps, burial preparation rooms, public swimming pools and Grade A milk certification. Staff members also offer technical assistance and provide guidelines for private water supplies and residential sewage systems.

HEALTH FACILITIES

ISDH programs serve Iowans of all ages and the elderly are included prominently. Many of Iowa's older citizens live in nursing homes and the Division of Health Facilities seeks to assure their accommodations, equipment and services meet standards of health and safety.

The Division of Health Facilities has responsibilities related to the construction of a nursing home or the expansion of an existing hospital. Help is given with the planning and preparation of these projects. These activities aid in bringing about compliance with federal regulations.

PERSONAL AND FAMILY HEALTH

A whole spectrum of programs are administered by the Division of Personal and Family Health to serve the needs of women of childbearing years, infants and children.

The Maternal and Child Health Section sponsors maternal health centers in 14 counties to help pregnant women with prenatal care, health education, nutritional, social, and preventive dental services. Child health centers and screening services also exist in 33 counties with the help of this section.

The WIC (Women, Infants and Children) Supplemental Food Program provides nutrition education and healthy foods to eligible pregnant and nursing women, and infants and children under five years of age.

Family planning agencies are distributed throughout the state to facilitate service in all 99 counties. These clinics provide physical examinations, laboratory tests, contraceptive counseling and referral to other agencies. Client education is a vital part of this program.

Education is important to the Genetic Consultation Program which is available to families

with potential genetic problems. Counseling helps these couples understand the risk of having a baby with a birth defect or genetic disease.

As many as 75 babies in Iowa each year are victims of Sudden Infant Death Syndrome (SIDS). This occurs when an apparently healthy infant is put to bed and is later found dead. The SIDS Program helps educate public health nurses and parents about this unexplained killer of infants.

Other programs include:

- A Rheumatic Fever Prophylaxis Program to prevent the recurrence of rheumatic fever in patients from birth to age 21,

- Prenatal classes, providing preparation for childbirth and parenthood, and

- A Perinatal Care Program which provides consultation and education to regional and community hospitals teaching care techniques for high-risk women and their newborns.

Programs aimed at the prevention and control of dental disease are the responsibility of the Dental Health Section. Again, education is vital. Dental hygienists visit lower elementary classrooms to teach children how to care for their teeth.

Water fluoridation is extremely effective in preventing decay. Help is given small towns with the initial cost of water fluoridation equipment. Surveillance is also made of existing water systems to insure optimum fluoride levels are maintained.

OFFICE OF EXTERNAL AFFAIRS

Iowa law requires individuals in certain health professions to be licensed before practicing in Iowa. The Office of External Affairs supervises the administration of the barber, chiropractic, cosmetology, dentistry, hearing aid dealer, medical, mortuary science, nursing home administrator, physical therapy, podiatry, psychology, optometry and speech pathology and audiology licensing boards.

This office also serves as a liaison with other agencies, elected officials and the legislature, and offers legal, technical and advisory services to all segments of the department.

OFFICE OF MANAGEMENT AND BUDGET

Births, deaths and marriages that have occurred in Iowa since 1880 — totaling over 10 million records — are filed in the Vital Records section of the Office of Management and

STATE DEPARTMENT OF HEALTH

(Continued from page 447)

Budget (OMB). Information on annulments and divorces is also recorded. These records not only document personal history but are used to gather statewide statistical information.

OMB provides complete management services for the department including budgeting, accounting, personnel administration, statistical information, data processing, purchasing, public information and health education.

OFFICE OF HEALTH PLANNING AND DEVELOPMENT

The Office of Health Planning and Development engages in health planning activities as prescribed under state and federal law. It develops, maintains and updates an Iowa health plan.

September 1979 Morbidity Report

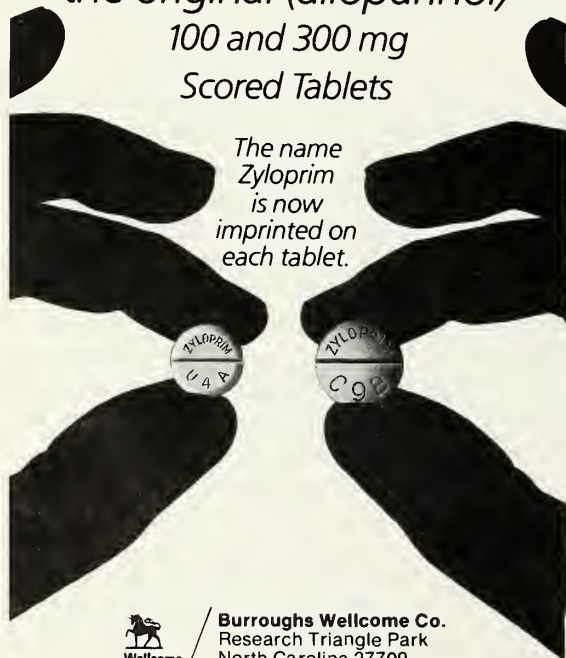
Disease	Sept. 1979 Total	1979 to Date	1978 to Date	Most Sept. Cases Reported From These Counties
Amebiasis	5	74	133	Baone, Bremer
Brucellosis	2	6	13	Clay, Dubuque
Chickenpox	57	7142	5738	Johnson, Muscotine, Scott
Cytomegalovirus	1	9	15	Boone
Eaton's Agent infection	0	35	104	—
Encephalitis	5	50	17	Linn, Manana, Wapello
Erythema infectiosum	0	1071	50	—
Gastroenteritis (GIV)	778	13929	13280	Black Hawk, Linn, O'Brien
Giardiasis	6	33	26	Bremer, Dickinson, Linn
Hepatitis, A	14	153	108	Johnson, Palk
Hepatitis, B	10	78	79	Polk
type unspecified	13	51	50	Linn, Polk
Herpes simplex	7	56	60	Jahnsen, Linn
Herpes Zoster	0	1	70	—
Histoplasmosis	0	2	3	—
Infectious mononucleosis	11	413	882	Marian, Palk
Influenza, lab confirmed	0	34	175	—
Influenza-like illness (URI)	1952	42722	39212	Linn, Polk, Story
Meningitis				
aseptic	22	55	26	Linn, Polk, Scott
bacterial	4	88	40	Dubuque, Iowa
meningococcal	1	10	14	Warren
Mumps	5	233	134	Black Hawk, Emmet
Pertussis	0	2	1	—
Rabies in animals	14	142	109	Hardin
Rheumatic fever	0	10	28	—
Rubella (German measles)	0	52	53	—
Rubeola (measles)	0	16	57	—
Salmonella	19	128	143	Palk, Scott, Bremer
Shigella	13	62	34	Lee, Scott
Tuberculosis				
total ill	6	58	85	Palk, Tama
bact. pas.	6	51	60	Polk, Tama
Venereal diseases:				
Gonorrhea	382	4345	4145	Jahnsen, Linn, Polk
P. & S. Syphilis	1	28	29	Benton, Johnson, Wadbury

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Guillian Barré — 1, Black Hawk; Caxsackie — 1, Polk; Typhoid — 2, Scott; Echavirus — Scattered.

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IOWA MEDICAL ASSISTANTS

NATIONAL CONVENTION

"When The Saints Go Marching In, I want to be in that number." And "that number" included jazz, jasmine and education. Thirteen medical assistants from Iowa were among over 1,000 members who joined together in historic New Orleans October 1 to 6. The 23rd annual convention of the American Association of Medical Assistants (AAMA) had sessions on subjects such as "Holistic Health Care," "Stress and the Management of Time," "Medical Law and Ethics," "Radiologic Sciences" and "Forensic Medicine." Special-interest sessions ranged from office administration and management to microbiology and pregnancy testing.

CODE OF ETHICS

The AAMA Code of Ethics sets forth principles of ethical and moral conduct as they relate to the medical profession and the particular practice of medical assisting.

Association members are dedicated to the conscientious pursuit of their profession, and desire to merit the regard of the entire medical profession and the respect of the general public which they serve. They pledge themselves to strive always to: (a) Render service to humanity with full respect for the dignity of person. (b) Respect confidential information gained through employment unless legally authorized or required by responsible performance of duty to divulge such information. (c) Uphold the honor and high principles of the profession and accept its disciplines. (d) Seek to continually improve our knowledge and skills of medical assisting for the benefit of patients and pro-

AAMA is a national, non-profit organization dedicated to the advancement of individuals who work in physicians' offices and other medical facilities. It is the oldest and largest association of its kind, with a national membership of 19,000. It offers a wide range of educational services to its members, including certification in basic medical assisting and administrative and clinical specialties; a Continuing Education Unit (CEU) approval program for chapter and state-sponsored educational programs; and cooperation with the American Medical Association (AMA) and the Committee on Allied Health Education and Accreditation (CAHEA) for the accreditation of post-secondary medical assisting programs.

The House of Delegates approved a \$5 dues increase effective in 1980. See your next issue of the "Professional Medical Assistant" for detailed information.

The newly elected officials of AAMA are Jean Mobley, CMA-AC, Texas, president; Mabel Ann Veech, CMA, Kentucky, vice-president; Dot Sellars, CMA-A, Virginia, president-elect; Dorothy Hartel, CMA-A, Maryland, secretary-treasurer, and trustees: Jayne Cook CMA-A, Utah; Jackie Fehling, Pennsylvania; Janet Hensinger, CMA-A, Kentucky; Bonnie Ingwersen, Nevada; Rachel Younger, C (ASCP), CMA-ACPed, Tennessee.

fessional colleagues. (e) Participate in additional service activities which aim toward improving the health and well-being of the community.

For further information about membership in AAMA or our certification program, contact either a state officer or the chapter president in your area. Chapter presidents are: Black Hawk, Sandy Hayungs, CMA-C, LaPorte City; Des Moines, Betty Ehlert, CMA-A, Des Moines; Linn County, Kathy Kammeyer, Cedar Rapids; Mason City, Pam Christensen, CMA, Mason City; Scott, Mary Ann Jaros, Davenport; and Siouxland, Joann Hansen, Sioux City.

Officers of the Iowa State Society are Nina Kline, CMA-LPN, Waterloo, president; Doris Liggett, CMA-AC, Des Moines, president-elect; Donna Haney, CMA-AC, Des Moines, vice-president; Margaret Gardner, CMA, Waterloo, secretary; and Mary Ann Jaros, Davenport, treasurer.

ABOUT IOWA PHYSICIANS

Dr. Barbara V. Koenig has joined the Surgery Department at the Park Clinic in Mason City. Dr. Koenig received the M.D. degree at U. of I. College of Medicine; interned at Ramsey County Hospital in St. Paul, Minnesota; and completed her surgery residency at St. Joseph Mercy Hospital in Ann Arbor, Michigan.

The following physicians have joined the Burlington Medical Center — **Dr. Michael R. Wilson**, an orthopedic surgeon, comes to Burlington from the Mayo Clinic in Rochester, Minnesota; **Dr. James H. Small**, radiologist, formerly practiced in Canada; **Dr. James A. Hendrix**, pediatrician, is a U. of I. College of Medicine graduate; **Dr. Gregory L. Day**, radiologist, is a Johns Hopkins medical school graduate; **Dr. William R. Daws**, pediatrician, is a U. of I. College of Medicine graduate; and **Dr. B. Ajaikumar** (Dr. A. J.), radiation oncologist, comes to Burlington from the Anderson Hospital and Tumor Institute in Houston, Texas. . . . **Dr. Donald Otilie**, Oelwein, recently was presented a plaque by the Oelwein Chamber of Commerce recognizing his long service to the community. Dr. Otilie is relocating in California. . . . **Dr. Randolpho DeLeon**, formerly of Wise, Virginia, opened a private practice of surgery in Osceola in August. Dr. DeLeon received his medical education at the Universidad De San Carlos of Guatemala, and completed his surgery residency at Washington Hospital Center in Washington, D. C. Prior to locating in Virginia, Dr. DeLeon practiced with Dr. Robert Thompson in Eldora, Iowa. . . . **Dr. Dean L. McGinty** joined the Muscatine Health Center staff in August. Dr. McGinty recently completed his family practice residency at the University of South Carolina Medical School. . . . **Dr. Kevin L.**

Sand recently joined Medical Associates in Decorah. Dr. Sand received the M.D. degree at U. of I. College of Medicine and completed his family practice residency in Rockford, Illinois.

Dr. C. C. Christiansen, retired Grand Mound physician, was honored recently at an open house in observance of his 33 years of medical service to the community. . . . **Dr. Larry R. Fane**, Mason City pediatrician, has been appointed by Governor Robert Ray to the Iowa Council for Children. . . . **Dr. L. G. Schaeferle** has sold his medical practice in Gladbrook to Family Medical Services of Marshalltown. Dr. Schaeferle will join the FMS group and continue to practice in Gladbrook for the next year or two. . . . **Dr. Dallas O. Minchin**, Council Bluffs, has been reappointed by Governor Robert Ray to the Commission on substance Abuse. . . . **Dr. G. W. Loerke**, Ottumwa, was guest speaker at recent meeting of the Goldfinch Chapter, American Business Women's Association. Dr. Loerke spoke on cancer of the colon.

Dr. William deGravelles, Jr., Des Moines, has received the National Physician of the Year award from the President's Committee on Employment of the Handicapped at the American Medical Congress on Occupation Health. Dr. deGravelles was cited for his work in advancing employment opportunities for disabled people. He was first chief of physical medicine and rehabilitation at Younker Memorial Rehabilitation Center in Des Moines when it opened 20 years ago. . . . **Dr. Ervin A. Kjenaas** is now superintendent of the Cherokee Mental Health Institute. Dr. Kjenaas has been director of training and research at CMHI for the past 10 years. . . . **Dr. Herman P. Musch** began pediatric practice in Marshalltown in August. Dr. Musch attended medical school at the Major University of San Simon Medical School in Cochabamba, Bolivia; interned at Mercy Hospital in Des Moines and completed his pediatric residency at Iowa Methodist Medical Center. . . . **Dr. Victor V. Ionasescu**, professor of pediatrics, U. of I. College of Medicine, has received a \$31,000 research grant from the Muscular Dystrophy Association of America. His study will concern the influence of various drugs on protein synthesis and creatine kinase in muscle cell cultures from muscular dys-

...in the functional bowel/irritable bowel syndrome*

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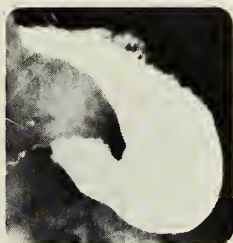
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with minimal anticholinergic side effects†

Demonstrated smooth muscle relaxant activity.

In this double-blind study, twenty patients having G.I. series and exhibiting spasm were randomly selected to receive either 2 cc. of Bentyl or sodium chloride intramuscularly. Ten minutes after the injection another radiograph was taken . . .

. . . Bentyl produced definite relaxation in 8 of 10 patients. The sodium chloride produced relaxation in only 3 of 10. No side effects occurred in either group of patients.



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"The correlation of spasm relief and drug given was excellent."

*This drug has been classified "probably" effective in treating functional bowel/irritable bowel syndrome.

†See Warnings, Precautions and Adverse Reactions.

See following page for prescribing information.

Reference:

King, J.C. and Starkman, N.M.: Evaluation of an antispasmodic. Double-blind evaluation to control gastrointestinal spasms occurring during radiographic examination. A preliminary report. Western Med. 5:356-358, 1964.

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Brief Summary

INDICATIONS

Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the following indications as "probably" effective:

For the treatment of functional bowel/irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis.

THESE FUNCTIONAL DISORDERS ARE OFTEN RELIEVED BY VARYING COMBINATIONS OF SEDATIVE, REASSURANCE, PHYSICIAN INTEREST, AMELIORATION OF ENVIRONMENTAL FACTORS.

For use in the treatment of infant colic (syrup).

Final classification of the less-than-effective indications requires further investigation.

CONTRAINDICATIONS: Obstructive uropathy (for example, bladder neck obstruction due to prostatic hypertrophy); obstructive disease of the gastrointestinal tract (as in achalasia, pyloro-duodenal stenosis); paralytic ileus, intestinal atony of the elderly or debilitated patient; unstable cardiovascular status in acute hemorrhage; severe ulcerative colitis; toxic megacolon complicating ulcerative colitis; myasthenia gravis. **WARNINGS:** In the presence of a high environmental temperature, heat prostration can occur with drug use (fever and heat stroke due to decreased sweating). Diarrhea may be an early symptom of incomplete intestinal obstruction, especially in patients with ileostomy or colostomy. In this instance treatment with this drug would be inappropriate and possibly harmful. Bentyl may produce drowsiness or blurred vision. In this event, the patient should be warned not to engage in activities requiring mental alertness such as operating a motor vehicle or other machinery or perform hazardous work while taking this drug. **PRECAUTIONS:** Although studies have failed to demonstrate adverse effects of dicyclomine hydrochloride in glaucoma or in patients with prostatic hypertrophy, it should be prescribed with caution in patients known to have or suspected of having glaucoma or prostatic hypertrophy. Use with caution in patients with: Autonomic neuropathy. Hepatic or renal disease. Ulcerative colitis. Large doses may suppress intestinal motility to the point of producing a paralytic ileus and the use of this drug may precipitate or aggravate the serious complication of toxic megacolon. Hyperthyroidism, coronary heart disease, congestive heart failure, cardiac arrhythmias, and hypertension. Hiatal hernia associated with reflux esophagitis since anticholinergic drugs may aggravate this condition.

Do not rely on the use of the drug in the presence of complication of biliary tract disease. Investigate any tachycardia before giving anticholinergic (atropine-like) drugs since they may increase the heart rate. With overdosage, a curare-like action may occur. **ADVERSE REACTIONS:** Anticholinergics/antispasmodics produce certain effects which may be physiologic or toxic depending upon the individual patient's response. The physician must delineate these. Adverse reactions may include xerostomia; urinary hesitancy and retention; blurred vision and tachycardia; palpitations; mydriasis; cycloplegia; increased ocular tension; loss of taste; headache; nervousness; drowsiness; weakness; dizziness; insomnia; nausea; vomiting; impotence; suppression of lactation; constipation; bloated feeling; severe allergic reaction or drug idiosyncrasies including anaphylaxis; urticaria and other dermal manifestations; some degree of mental confusion and/or excitement, especially in elderly persons; and decreased sweating. With the injectable form there may be a temporary sensation of lightheadedness and occasionally local irritation. **DOSAGE AND ADMINISTRATION:** Dosage must be adjusted to individual patient's needs.

Usual Dosage: Bentyl 10 mg. capsule and syrup: *Adults:* 1 or 2 capsules or teaspoonful syrup three or four times daily. *Children:* 1 capsule or teaspoonful syrup three or four times daily. *Infants:* ½ teaspoonful syrup three or four times daily. (May be diluted with equal volume of water.) Bentyl 20 mg.: *Adults:* 1 tablet three or four times daily. Bentyl Injection: *Adults:* 2 ml. (20mg.) every four to six hours intramuscularly only. NOT FOR INTRAVENOUS USE. **MANAGEMENT OF OVERDOSE:** The signs and symptoms of overdose are headache, nausea, vomiting, blurred vision, dilated pupils, hot, dry skin, dizziness, dryness of the mouth, difficulty in swallowing, CNS stimulation. Treatment should consist of gastric lavage, emetics, and activated charcoal. Barbiturates may be used either orally or intramuscularly for sedation but they should not be used if Bentyl with Phenobarbital has been ingested. If indicated, parenteral cholinergic agents such as Urecholine® (bethanechol chloride USP) should be used.

Product Information as of October, 1978.

Injectable dosage forms manufactured by CONNAUGHT LABORATORIES, INC., Swiftwater, Pennsylvania 18370 or TAYLOR PHARMACAL COMPANY, Ocaturo, Illinois 62525 for MERRELL-NATIONAL LABORATORIES, Division of Richardson-Merrell Inc., Cincinnati, Ohio 45215, U.S.A.

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Cincinnati, Ohio 45215, U.S.A.

ABOUT IOWA PHYSICIANS

(Continued from page 450)

trophy patients. . . . **Dr. Milo Jeffries**, longtime Marshalltown obstetrician and gynecologist, retired August 1. Dr. Jeffries received the M.D. degree from Northwestern University, interned at Chicago's Wesley Memorial Hospital and had his obstetrics and gynecology residency at Northwestern. He joined the Marshalltown Medical and Surgical Clinic in 1948.

Dr. Victor Suarez closed his practice in Anthon October 25 to relocate in Miami, Florida. . . . **Dr. and Mrs. C. W. Rainy**, Elma, were honored at an open house marking Dr. Rainy's 25 years of service to the community. A plaque noting the event was presented to Dr. Rainy. . . . **Dr. Dale Harding**, Eagle Grove, was guest speaker at a recent meeting of the Webster City Kiwanis. He spoke on the importance of nutrition. . . . **Dr. Bruce Mason**, Ottumwa, has been appointed Wapello County medical examiner and **Dr. H. L. Wormhoudt**, Ottumwa, deputy medical examiner. . . . **Dr. Harold C. Rankin**, Mt. Pleasant, was elected president of the Kidney Foundation of Iowa at the annual meeting of the Foundation's Board of Directors. Dr. Rankin is director of dialysis at the Henry County Health Center. . . . **Dr. Edmund A. Franken, Jr.** has been appointed professor and head of the Department of Radiology at U. of I. College of Medicine. Dr. Franken received the M.D. degree from the University of Oklahoma and took his specialty training in radiology at Indiana University Hospitals. Prior to locating in Iowa, he was a professor in the Department of Radiology at Indiana University. . . . **Dr. Pauline Miller** and **Dr. Robert Patterson** have joined the Iowa State University Student Health Service in Ames. Dr. Miller recently completed her family practice residency at Iowa Lutheran Hospital in Des Moines. Dr. Patterson has been engaged in family practice in Conrad, Iowa, for 18 years.

Five new doctors have joined the McFarland Clinic in Ames. They are — **Dr. Jack Cooksey** and his wife, **Dr. Judith Cooksey**, **Dr. Dale P. Anderson**, **Dr. L. Ralph Rogers** and **Dr. Michael J. Kitchell**. Dr. Jack Cooksey received the M.D. degree at Harvard Medical School

and had his internal medicine residency at the University of Illinois School of Medicine. Dr. Judith Cooksey received the M.D. degree at University of Illinois School of Medicine and had her internal medicine residency at the University of Chicago. Dr. Anderson received the M.D. degree from Northwestern University and had his internal medicine residency at Eastern Virginia Graduate Program in Norfolk, Virginia. Dr. Rogers received the M.D. degree at University of Louisville College of Medicine and had his residency in obstetrics and gynecology at Baylor University. Dr. Kitchell received the M.D. degree at U. of I. College of Medicine and had his neurology residency at University Hospitals in Iowa City. . . . **Dr. Richard B. Rubenstein** has joined **Dr. Theodore P. Roman** in Sioux City. Dr. Rubenstein received the M.D. degree from the State University of New York/Downstate Medical Center in Brooklyn; served his surgery residency at Beth Israel Medical Center in New York and had his cardiothoracic residency at Charlotte Memorial Hospital and Medical Center in Charlotte, North Carolina. . . . **Dr. James W. Hanson**, assistant professor of pediatrics at U. of I. College of Medicine, has received a \$24,000 March of Dimes birth defects

research grant. Dr. Hanson will study the birth defects of offspring of epileptic pregnant women associated with anticonvulsant drug.

Dr. Robert R. Shreck recently opened an office in Des Moines to practice internal medicine. Dr. Shreck received the M.D. degree at U. of I. College of Medicine and had his internal medicine residency and a fellowship in oncology and hematology at the University of Utah. . . . **Dr. Steven R. Ellison** has joined the Ottumwa Medical Clinic. Dr. Ellison received the M.D. degree at U. of I. College of Medicine and completed his internal medicine residency at University Hospitals. . . . **Dr. R. Paul Penningroth** and **Dr. Robert W. Shultice**, psychiatrists at the Linn Community Mental Health Center, will establish a private practice in Cedar Rapids in January, 1980. Dr. Shultice has been with the mental health center since 1967 and has served in a number of capacities, including director and clinical services supervisor. Dr. Penningroth has been with the center eight years and is currently acting medical director. Their practice will be named the Cedar Center Psychiatric Group. . . . **Dr. John J. Keith**, Marion physician for over 40 years, retired from medical practice in September. Dr.

BOONDOCKS MEETS AGAIN

The second annual meeting of the *Boondocks Medical Society* was August 25 in Mason City. Approximately 200 attended. Reports have it the newly appointed international executive director of the BMS, one J. Scalpel Paré, M.D., was absent due to a health planning meeting in Katmandu, Nepal. A. J. Herlitzka, M.D., chaired in his absence.

Secretary Lyle Fuller, M.D., Garner, received approval to his reading of the organizational minutes. BMS articles of incorporation have been adopted even though there are some reports they have been lost in the mail.

Special BMS awards were presented as follows: HOLP Award (Hundreds of Little People) 38 years of service — G. J. Sartor, M.D., Mason City; NIFSOS Award (North Iowa's Favorite Son of Switzerland) 30 years of service — Werner Pelz, M.D., Charles City; JSPGR Award (J. Scalpel Paré Golden Retrac-

tor) 36 years of service — E. H. Barg, M.D., Mason City; PACS Award (President's Award for Community Service) 33 years of service — Wendell Taylor, M.D., Sheffield. In absentia awards were made to D. L. Long, M.D., 34 years' service; H. J. Roddy, M.D., Mason City, 37 years' service; W. H. Owen, M.D., St. Ansgar, 32 years' service; B. H. Osten, M.D., Northwood, 40 years' service; Monroe Allison, M.D., Northwood, 43 years' service; L. W. Swanson, M.D., Mason City, 36 years' service. Special recognition was given Mike Coleman, M.D., and Mike Welton, M.D., residents at the University of Iowa.

M. C. Jones, M.D., and M. G. Sloan, M.D., represented the Boone County Medical Society, and claimed to be part of another organization known as the "Boone Docs" of Boone, Iowa. This organization is in sympathy with the goals of the Boondocks Medical Society, namely to promote euphoria and fellowship within the profession.

ABOUT IOWA PHYSICIANS

(Continued from page 453)

Keith received the M.D. degree from Rush Medical College at the University of Chicago. He began his practice in Marion in 1936.

Dr. Richard M. Freeman, professor in the Department of Internal Medicine, recently received the Distinguished Service Award presented by the Kidney Foundation of Iowa. . . .

Dr. Keith Barnett has been named psychiatric consultant for the Siouxland Mental Health Center in Sioux City. Dr. Barnett received the M.D. degree from the California College of Medicine in Los Angeles; interned in Bay Village, Ohio; and had his psychiatric residency at the Mental Health Institute in Cherokee, Iowa. . . .

Dr. B. J. Broghammer, Mason City radiologist, was guest speaker at a recent meeting of the Wright County Medical Society. Dr. Broghammer discussed new radiology equipment.

DEATHS

Dr. Robert P. Lichtenberg, 62, Keokuk, died September 11 at Methodist Hospital in Rochester, Minnesota. Dr. Lichtenberg received the M.D. degree from New York University School of Medicine; interned at Bellevue Hospital in New York City; and had a surgery residency at Lincoln Hospital in New York City and Hurley Hospital in Flint, Michigan. A Keokuk physician for the past 22 years, Dr. Lichtenberg was vice president of the medical staff and member of the board of trustees at Keokuk Area Hospital, where he formerly served as chief of staff. He was a fellow of the American College of Surgeons and of the American College of Abdominal Surgeons.

Dr. J. R. Shorey, 75, Davenport, died September 15 following an automobile accident in California. Dr. Shorey received the M.D. degree at U. of I. College of Medicine. He had practiced medicine in Davenport since 1931. Dr. Shorey was a former Scott County medical examiner; former president of St. Luke's Hospital medical staff and a past president of Scott County Medical Society.

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Each capsule contains 5 mg. chlordiazepoxide HCl and 2.5 mg. clidinium Br.

Please consult complete prescribing information, a summary of which follows:

Indications: Based on a review of this drug by the National Academy of Sciences—National Research Council and/or other information, FDA has classified the indications as follows: "Possibly" effective: as adjunctive therapy in the treatment of peptic ulcer and in the treatment of the irritable bowel syndrome (irritable colon, spastic colon, mucous colitis) and acute enterocolitis. Final classification of the less-than-effective indications requires further investigation.

Contraindications: Glaucoma; prostatic hypertrophy, benign bladder neck obstruction; hypersensitivity to chlordiazepoxide HCl and/or clidinium Br.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants, and against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Physical and psychological dependence rarely reported on recommended doses, but use caution in administering Librium® (chlordiazepoxide HCl/Roche) to known addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions) reported following discontinuation of the drug.

Usage in Pregnancy: Use of minor tranquilizers during first trimester should almost always be avoided because of increased risk of congenital malformations as suggested in several studies. Consider possibility of pregnancy when instituting therapy. Advise patients to discuss therapy if they intend to or do become pregnant.

As with all anticholinergics, inhibition of lactation may occur.

Precautions: In elderly and debilitated, limit dosage to smallest effective amount to preclude ataxia, oversedation, confusion (no more than 2 capsules/day initially; increase gradually as needed and tolerated). Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider pharmacology of agents, particularly potentiating drugs such as MAO inhibitors, phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions reported in psychiatric patients. Employ usual precautions in treating anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship not established.

Adverse Reactions: No side effects or manifestations not seen with either compound alone reported with Librax. When chlordiazepoxide HCl is used alone, drowsiness, ataxia, confusion may occur, especially in elderly and debilitated, avoidable in most cases by proper dosage adjustment, but also occasionally observed at lower dosage ranges. Syncope reported in a few instances. Also encountered: isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent, generally controlled with dosage reduction; changes in EEG patterns may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice, hepatic dysfunction reported occasionally with chlordiazepoxide HCl, making periodic blood counts and liver function tests advisable during protracted therapy. Adverse effects reported with Librax typical of anticholinergic agents, i.e., dryness of mouth, blurring of vision, urinary hesitancy, constipation. Constipation has occurred most often when Librax therapy is combined with other spasmolytics and/or low residue diets.



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PRESIDENT'S PRIVILEGE

The American Medical Association is embarked on a crash membership drive. Presently, the AMA has about 220,000 members, of whom 40,000 are equally divided among medical students and residents. This represents 40% of the practicing physicians and 30% of the medical students and residents.

The level of activity of the AMA in the courts, the Congress and HEW is moving ahead at an ever increasing tempo. More and more the AMA is being looked upon as the spokesman for all of MEDICINE. And of course, when convenient politically, it becomes the medical whipping-boy of the politicians and press. The issues at stake are mounting in both numbers and complexity, particularly from a legal and regulatory standpoint. Few of the problems have simple solutions. Certainly none that can be solved by just voting a conservative ticket.

As physicians, we require a strong national organization to marshal the sophisticated political and legal resources needed to represent us, and yet be organized in a way which is responsive to the constituent membership.

The AMA is organized to function in just this

way. It has a strong full-time staff charged to execute the policies of the Association as developed by the House of Delegates — the locally elected representatives of the physicians in the Association. Like all democratic organizations, the majority rules, which means the minority is often overruled. So it is not surprising to find most physicians have disapproved of an AMA action at sometime or another; just as few citizens find themselves in agreement with Congress and the President all of the time.

A government not representing its constituents can be changed on election day — so the AMA can be changed through the election of physicians to its House of Delegates. But citizens not registered, can't vote; nor can protesting physicians impact on AMA policy by remaining non-members.

The AMA needs all of us and, sooner or later, we all will need the AMA.

Paul M. Seebohm M.D.
Paul M. Seebohm, M.D.

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1980 IMS/Aetna Rates Unchanged; New Dividend Is Highest Yet

New dividend brings total returned to IMS/Aetna insured physicians to over one million dollars. Annual report discloses no change in premiums for 1980. Concern is expressed over national upward trend in malpractice losses.

NINETEEN EIGHTY malpractice premiums will remain unchanged for those member physicians who participate in the Iowa Medical Society/Aetna Liability Insurance Program. On top of that, the nearly 1,100 physicians insured under the program will share in a half million dollar dividend.

This good news highlighted the third annual report on the IMS/Aetna program presented to the Society in November by Aetna officials. The report received endorsement November 15 from the IMS Executive Council. And on recommendation of the Society's Medico-Legal Committee, the program was approved for continuation.

Participation in the IMS/Aetna program has increased by 127 insureds over one year ago. Approximately 45% of the eligible membership now participates in the program.

The coming year will be the third straight in which there has been no increase in rates. Two years ago premiums were decreased by an average of 3% and last year the rates were reduced an average of 7%. Actually, in 1980 there will be a one percent reduction in premium income to the program. This will result from the granting of a 20% premium discount to physicians in their first year of practice, followed by a 10% reduction in the second year.

DIVIDEND CALCULATION

The exact dividend calculation is \$529,521 or 18%. Dividends will range in individual amount from \$144 for a Class I physician to \$1,523 for a Class VII doctor. It is understood the dividend checks will be distributed with the 1980 premium renewal notices. Of particular and additional consequence is the fact, that for the first time, this dividend includes a

sharing of the interest earned by Aetna from investment of premium dollars. This interest level is 6% of the primary professional liability premium and represents \$168,802 of the total dividend.

This is the third dividend to be declared since the program was initiated and brings the total returned to participating insureds to over \$1.1 million. A dividend of \$240,291 was paid earlier this year.

Other program improvements to be initiated in 1980 include:

1) Higher limits for the defendants reimbursement coverage. The previous maximum was \$200 per day with a \$5,000 limit per suit. It will now be available as an option at higher limits of \$300/\$7,500. This coverage helps with expenses and loss of time resulting from required attendance as a defendant in a professional liability trial.

2) The combining of six coverages into a Med-Pak at a discounted premium of \$55. Included here are defendants' reimbursement, premises medical payments, employer's non-owned automobile liability, fire damage legal liability, personal injury and advertising offense and host liquor liability.

These 1980 program improvements will couple with those instituted in previous years to provide what the annual report describes as the "finest professional liability program available." A guarantee of coverage under the program was extended by Aetna last year to 1983.

NEW DIMENSION

Among its recommendations for 1980, the Aetna is suggesting formation by the IMS of an ad hoc committee to focus attention on the prevention of patient injury and to increase physician understanding of malpractice — all with the goal of improved patient care. This extension of existing efforts is being called Risk Management/Loss Prevention and is intended as an added dimension to the present Loss Control and Education Program.

The Aetna has announced it will make available one percent of the IMS primary profes-

sional liability premium or approximately \$28,000 to support the proposed Risk Management/Loss Prevention project. With advance agreement between the IMS and Aetna as to how, this sum will be used to finance activity which contributes materially to the objective of risk management and loss prevention.

Use in this program will be made of an Aetna Risk Management Tool Kit. This kit includes printed educational material, professional research studies, descriptions of videotapes available and a list of topics, for presentations given under the auspices of the IMS and Aetna. This expanded program will build on efforts this preceding year which included educational presentations before 41 county society, hospital staff and other medical group meetings.

In summary, it is hoped by Aetna the Risk Management/Loss Prevention Program will cover the identification, analysis and evaluation of risk-producing situations to be followed by the selection and implementation of activity to cut the risks to a minimum. It has not been determined how the IMS will respond to this new proposal.

Claim activity under the IMS/Aetna program from 10/1/78 to 9/30/79 is reflected in the following statistics:

	ARISINGS	CLOSINGS	TOTAL OUTSTANDING
CLAIMS	38	25	26
SUITS	11	4	7

When compared with the preceding year there has been a sharp increase in claim activity. This is attributed to two main reasons: 1) more insureds, and 2) the "long tail" of professional liability claim development. Of the 38 arisings, 25 are in four specialty areas: obstetrics/gynecology — 7; anesthesiology — 6; family practice — 6 and general surgery — 6. It is likely that physician claim review panels will be required during the year to consider several of these claims.

INFORMATION AVAILABLE

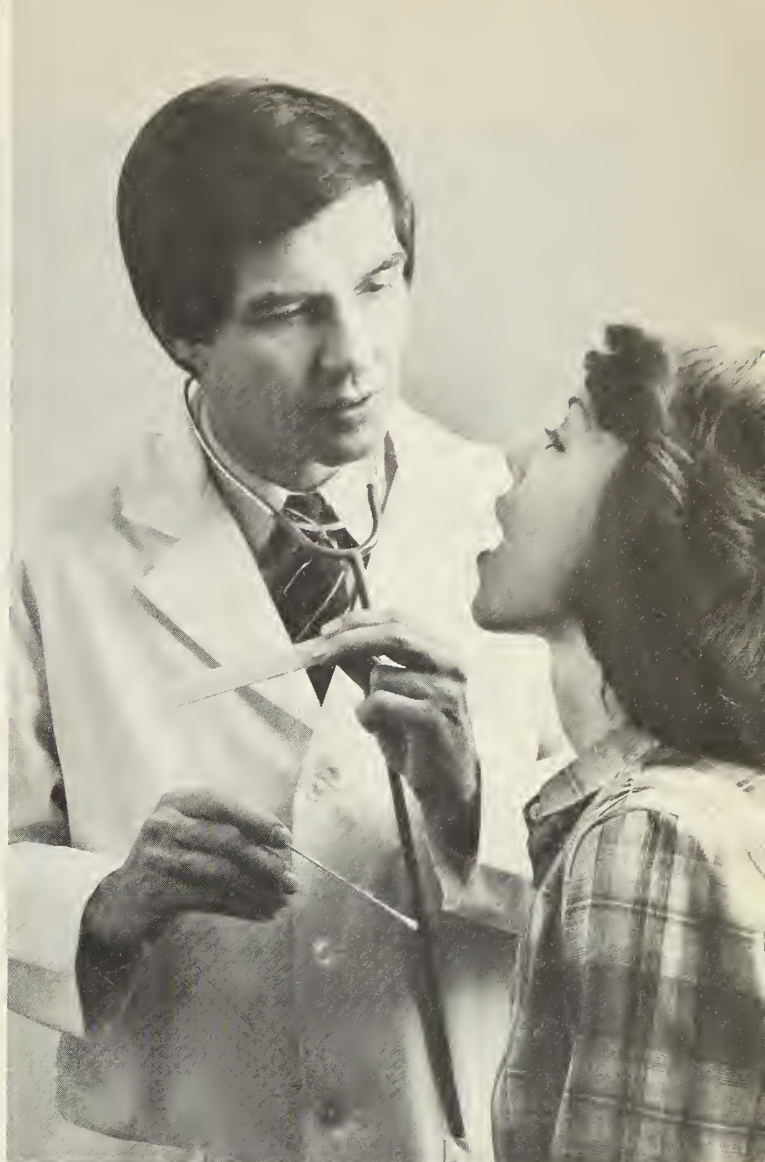
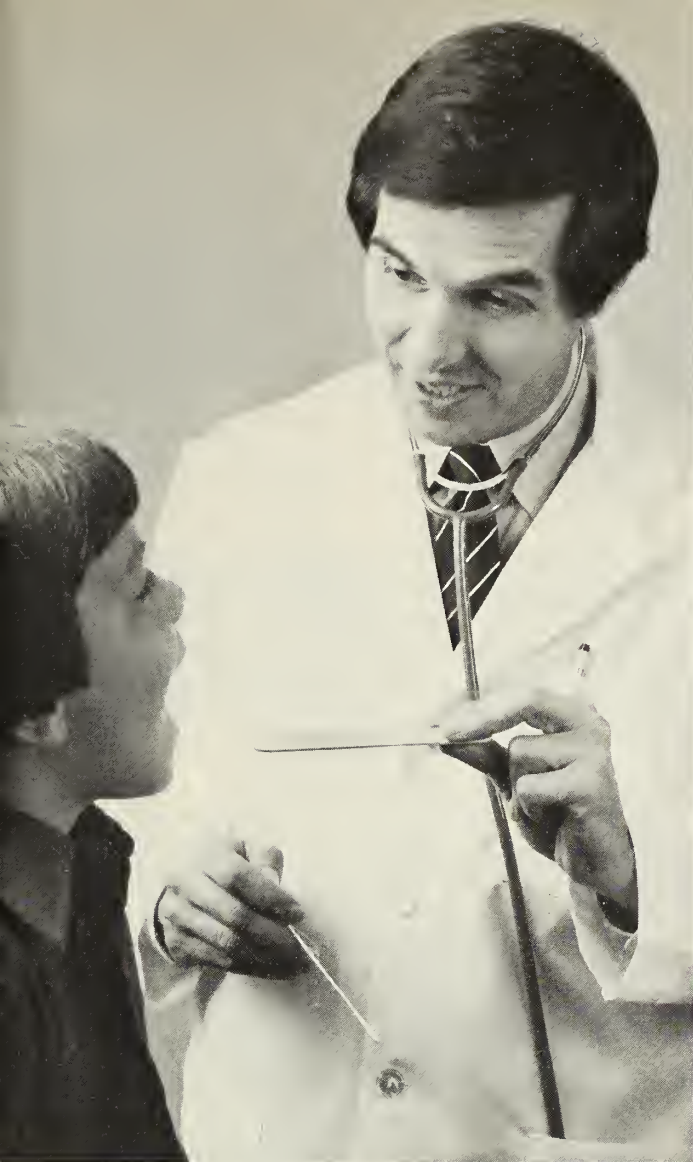
Information on the IMS/Aetna Liability Insurance Program may be obtained by calling either Society headquarters (1/800-422-3070) or Dave Heath, the Aetna account supervisor (1/800-362-1809). The coverage is placed through local Aetna agents.

IN-STATE MEDICAL MEETINGS

The following postgraduate courses and conferences will occur at U. of I. College of Medicine in Iowa City

Jan. 2	Ophthalmology Clinical Conference
Jan. 26	Radiation Therapy Seminar
Feb. 1-3	Advanced Cardiac Life Support Provider/ Instruction, Waterloo
Feb. 6	Ophthalmology Clinical Conference
Feb. 12-15	Refresher Course for the Family Practitioner
Feb. 20	Emergency Procedures for Physicians

Feb. 23	Radiation Therapy Seminar
Feb. 25-28	Cardiology Today
Jan. 9	Update on Pulmonary Disorders — Mercy Hospital Medical Center, Des Moines — Sponsor: Mercy Hospital Medical Center
Jan. 25	Pediatric Toxicology — St. Joseph Mercy Hospital, Mason City — Sponsors: St. Joseph Mercy Hospital and U. of I. College of Medicine
Feb. 19	Review of Prostatic Carcinoma — St. Joseph Mercy Hospital, Mason City — Sponsors: St. Joseph Mercy Hospital and U. of I. College of Medicine
Feb. 21	Hemotherapy for Cancer and Leukemic Patients — Moline Lutheran Hospital, Moline, Illinois — Sponsor: Mississippi Valley Regional Blood Center
Mar. 28	Chronic Abdominal Pain in Children — St. Joseph Mercy Hospital, Mason City — Sponsors: St. Joseph Mercy Hospital and U. of I. College of Medicine



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QUESTIONS - ANSWERS

DANIEL F. CROWLEY, M.D.
DES MOINES

THE PAST! THE FUTURE?

Dr. Crowley is a veteran member of the Journal Scientific Editorial Panel. He is a Des Moines native and has practiced general and thoracic surgery for 30 years. He is a 1938 medical graduate of the University of Iowa and had his surgical residency at the Mayo Clinic.

How would you characterize the decade now ending in terms of medical care?

It is impossible to partition the course of events into specific time periods, so I have interpreted "decade" somewhat loosely.

It seems to me there have been three outstanding and identifiable developments in medical care in recent years: The first can be described as an acceleration of the trend away from the *art of medicine* toward the *science of medicine*. The examination of laboratory and X-ray results is becoming more important than an examination of the patient. This has led to the common use of an astounding number of tests. In a similar vein, the medical history is now important primarily as a clue to what tests to order. This trend is not necessarily bad, but it is noteworthy.

A second characteristic is the emergence of a "team" concept — a team which may include

doctor, nurse, pharmacist, social worker, clergyman, and others. Now we even have a team to help people die.

A third characteristic is the resurgence of symptomatic therapy. There is a different pill for every symptom. One study revealed that an average hospital patient receives seven different medications during his hospital stay.

What one or two scientific and socio-economic developments stand out as the most significant of the decade?

A general surgeon would most likely mention, with mixed emotions, cimetidine at the head of the scientific list, for it has almost eliminated surgery in the treatment of peptic ulcer. But a somewhat broader viewpoint would include oncology, open heart surgery, joint replacement, and the CAT scan.

Socio-economic developments that stand out are: excessive court awards resulting in very great increases in the cost of malpractice insurance; the continuing encroachment of government, third parties, and others on the practice of medicine; and the awesome cost of up-to-date medical care. (I recently reviewed a hospital record in which the total hospital bill of a patient hospitalized 105 days was \$72,774, of which \$4,280 was for arterial blood gases alone.)

How does this decade compare with previous ones in your career?

The immense satisfaction inherent in the care of the sick, even with the attendant worries, remains the same, but much of the fun is gone. Proliferation of rules, administrative problems, utilization dicta, divided authority, public criticism — all of these have fostered a troubled medical environment, at least for those who have known a better day.

What do you see ahead in the 1980's?

Prophecy is beyond my competence, but some things can be predicted with reasonable certainty. I believe that in the years not too far ahead we will see a decline in doctors' incomes; greater selectivity in the indications for chemotherapy; organized medicine disengaging itself from PSRO; large numbers of doc-

(Please turn to page 476)

Metolazone for Effective Blood Pressure Reduction and Diuresis

JOHN L. HOYT, M.D.
Creston, Iowa

INCREASING ATTENTION is being paid to hypertension as a serious national medical problem. The benefit derived from the reduction of blood pressure in otherwise "healthy" and often non-symptomatic individuals has been documented in well-designed, prospective studies.^{1, 2} Such trials indicate a significant reduction in morbidity and mortality will result from broader application of available therapeutic regimens.

The essential role of diuretic agents in the rational approach to hypertension therapy has been reviewed recently.^{3, 4} Metolazone* is an antihypertensive/diuretic agent which is characterized by prolonged, 24-hour action after administration of small doses, usually 2.5 or 5 mg once daily.⁵

Some controlled clinical comparisons in hypertensive patients have demonstrated that

Metolazone, an antihypertensive/diuretic agent, was given 31 patients for treatment of hypertension or edema. All but 1 of 15 hypertensive patients responded to the drug. The mean blood pressure declined from 165/99 to 145/87 mm Hg during treatment. The report says 5 of the hypertensive patients have now received the drug for over one year with good results. Relief of edema was highly satisfactory in 13 of 16 patients. Only 3 patients in the total group experienced side effects, chiefly gastrointestinal symptoms requiring discontinuation of therapy.

metolazone was similar in efficacy and patient acceptability to hydrochlorothiazide⁶ and chlorthalidone.⁷ In one controlled crossover study, it was found a single daily dose of metolazone 5 mg significantly reduced blood pressure in 33 men with essential hypertension, as compared to hydrochlorothiazide 50 mg given twice daily.⁸ In a study reported by Cangiano,⁹ no problem was observed with developing tolerance to metolazone or increase in side effects in treatment periods of up to five years. Metolazone has also been found to be safe and effective in the treatment of edema due to liver, renal, or heart disease.¹⁰⁻¹²

These favorable reports of an anti-

Dr. Hoyt is associated with the Creston Medical Clinic, P.C., in the private practice of family medicine.

* Zaroxolyn®

hypertensive/diuretic agent which was potent, long-acting, and well tolerated encouraged us to introduce metolazone into our practice for treatment of essential hypertension or edema. This report details our initial experience with this agent.

PATIENTS AND METHODS

We identified 31 patients, 15 males and 16 females, from our records who had received metolazone during treatment. The drug was prescribed for 15 patients to control blood pressure, and for the other 16 to relieve edema. Mean age of the hypertensive and edematous patients was 61.6 and 68.7 years, respectively. The youngest was 28 years old and the oldest 94.

Among the hypertensive patients, the most commonly associated medical problems were obesity, osteoarthritis, and cardiac disease. Most of the patients were moderately to severely obese, with a mean weight before treatment of 185.9 lb. Mean blood pressure of these patients prior to initiation of metolazone therapy was 165/99 mm Hg. All had mild or moderate hypertension and only three had diastolic pressure less than or equal to 90 mm Hg before metolazone therapy was begun.

TABLE 1
HYPERTENSIVE PATIENTS TREATED WITH METOLAZONE

Pt. No.	Age	Sex	Blood Pressure (mm Hg)		
			Initial	Finol	Chonge
Metolazone olone					
01(EK)	57	M	185/100	144/90	-41/10
08(SO)	73	F	210/102	158/88	-52/14
11(LM)	73	M	144/94	144/88	-0/6
13(IS)	81	F	180/100	140/78	-40/22
14(DB)	46	M	170/110	130/80	-40/30
21(DS)	50	M	162/104	148/92	-14/12
22(HM)	53	F	168/108	148/82	-20/26
25(BD)	86	M	140/88	148/92	+8/4
31(RF)	67	M	172/100	150/80	-22/20
32(LR)	53	F	170/90	158/90	-12/0
33(PG)	69	F	150/100	140/90	-10/10
Meon			168/99	146/86	-22/13
Metolazone os concomitont medication					
09(WN)	53	M	200/110	148/80	-52/30
20(BW)	60	F	144/84	140/90	-4/+6
23(TF)	44	M	130/100	138/90	+8/-10
24(TB)	49	F	152/100	140/90	-12/10
Meon			157/99	142/88	-15/11
Total Group Meon			165/99	145/87	-20/12

Three patients had been recently diagnosed as hypertensive and had not been previously treated, while the remainder had received various antihypertensive agents, singly and in many combinations, with only fair results. Hydrochlorothiazide with either spironolactone or triamterene, or a combination of Rauwolfia, bendroflumethiazide, and potassium chloride were the drugs used most frequently in these patients. The pertinent characteristics of each hypertensive patient are shown in Table 1.

In the other 16 patients, 9 women and 7 men, edema was generally due to congestive heart failure or other cardiac disease. Obesity was a severe problem in many patients; the group's mean weight before treatment was 159.7 lb.

RESULTS

Hypertension Control

For the 15 hypertensive patients, metolazone was most commonly prescribed in a dosage of 5 mg once a day, although 4 patients received 10 mg daily, and 2 who were receiving 2.5 mg per day had their dosage schedule reduced to three days per week because of good response to the drug. The mean duration of treatment at the time of this review was 31 weeks, the maximum 80 weeks, and the minimum 2 weeks.

Mean blood pressure declined from 165/99 to 145/87 mm Hg during treatment, a mean decrease of 20/12 mm Hg. If only the 12 patients with diastolic hypertension (>90 mm Hg) are considered, the mean decrease in diastolic pressure was 16 mm Hg, from an initial mean of 102 mm Hg to 86 mm Hg after metolazone (Figure 1). Blood pressure control was maintained in the other 3 patients, i.e., those who were started on metolazone while their pressure was reasonably well controlled. Thus diastolic pressure of 13 of the 15 hypertensive patients treated with metolazone was less than or equal to 90 mm Hg at the time of this review. Of these patients, 2 (BD, LR) who had been having problems with side effects with hydrochlorothiazide containing agents were successfully switched to metolazone alone with no drug-related complaints.

The rapid and dramatic response to metolazone of a number of patients with refractory hypertension was particularly impressive. In one case, the blood pressure of a 53-year-old

obese woman (HM) had failed to respond to a number of antihypertensives, most recently a reserpine-hydralazine-hydrochlorothiazide combination. Her blood pressure measurement was 168/108 mm Hg when metolazone 5 mg daily was substituted. Six weeks later this patient's pressure had declined to 148/82 mm Hg. In a second case, the blood pressure of a 69-year-old severely obese woman (PG), with little previous response to hydrochlorothiazide-triamterene, declined from 150/100 mm Hg to 146/92 mm Hg within one week of starting a daily regimen of metolazone 5 mg. Two weeks later her reading was 140/90 mm Hg.

Metolazone was highly effective when used concomitantly with clonidine in a 53-year-old man (WN) with long-standing and refractory hypertension. Response was noted within two days of initiation of a regimen of metolazone 5 mg once daily and clonidine 0.1 mg twice daily, the patient's blood pressure declining from 200/110 mm Hg to 178/100 mm Hg. One week later his reading was 158/90 mm Hg, and in another week it was 148/80 mm Hg. Metolazone was administered together with guanethidine or guanethidine plus hydrochlorothiazide in two other patients (BW, TB) for whom these combinations provided effective control.

Very appreciable blood pressure reductions were achieved in the three patients who had received no prior antihypertensive therapy (IS, DB, RF). Two of these patients (IS and DB) have now received metolazone for 78 and 64 weeks respectively and are on three-day-per-week dosage schedules with good control. The only patient whose response to metolazone was disappointing was TF, a 44-year-old obese man diagnosed as hypertensive two years earlier. After a trial of a reserpine-hydralazine-thiazide combination as concomitant medication with hydrochlorothiazide and spironolactone, his blood pressure was still elevated at 130/100 mm Hg and his weight was 219 lb. Metolazone 10 mg daily was substituted for the reserpine combination, and his pressure reading during the next month varied between 132/92 and 148/100 mm Hg. Hydrochlorothiazide-triamterene then replaced hydrochlorothiazide-spironolactone as concomitant medication with similarly unimpressive results, although at the time all of these medications were discontinued the patient's

weight had declined to 191 lb. Ultimately his hypertension was better controlled with a regimen including methyldopa, guanethidine, and hydrochlorothiazide-triamterene, together with a 90 mEq sodium diet.

Edema Relief

Thirteen of the 16 patients who received metolazone for treatment of edema responded to the drug. Therapy was stopped in two patients because of side effects, and in a third better response was obtained with chlorothiazide. Metolazone was prescribed in doses of 2.5 to 10 mg daily for as little as one week and for as long as 16 months. Generally, patients obtained smooth and rapid diuresis on initial dosage schedules, although one patient required an increase in his 5-mg dose from once to twice daily for increased effect.

The drug was found to be effective for edema in a wide variety of clinical situations. Response was particularly impressive in one patient with edema due to congestive heart failure, who had failed to obtain relief with a

RESPONSE OF DIASTOLIC PRESSURE TO METOLAZONE

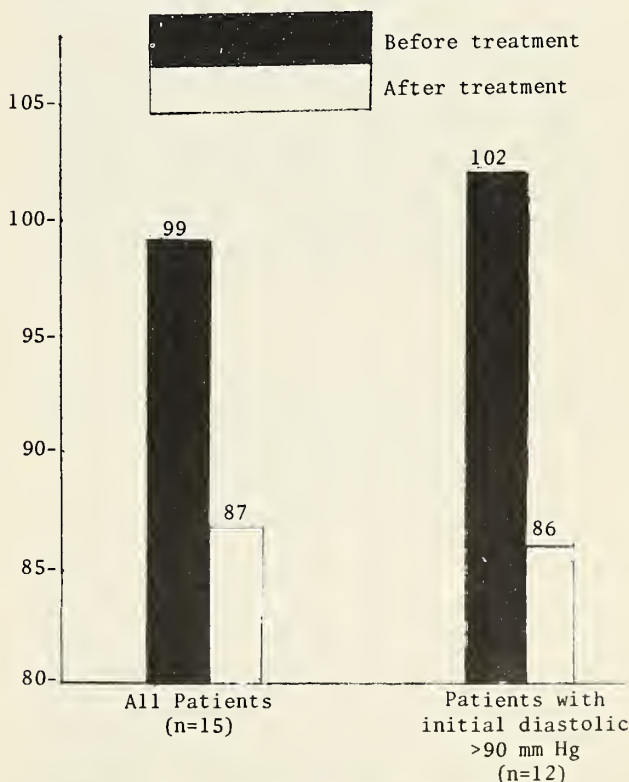


Figure 1. Response of diastolic pressure to metolazone.

number of diuretics, including furosemide, ethacrynic acid, and chlorothiazide. He obtained rapid diuresis when switched to metolazone.

Side effects were reported by three patients during the course of treatment with metolazone. One patient with profound hypochondriasis complained of gas pains while receiving the drug for hypertension. The other two patients experienced nausea and vomiting, accompanied in one instance by dizziness, during administration of the drug for relief of edema due to congestive heart failure. In all such cases of reduced patient acceptance, drug administration was discontinued and alternate therapy provided.

DISCUSSION

Metolazone was remarkably effective and very well tolerated in the group of patients under review. A satisfactory degree of blood pressure control was achieved in all but one of the hypertensive patients, and relief of edema was generally rapid and predictable. A number of patients in both the hypertensive and edematous groups experienced their first real response to treatment after being switched to metolazone.

The drug appeared to have a number of advantages over the thiazides. Problems with side effects were limited to three patients who complained of gastrointestinal symptoms. We did not observe symptoms of hypokalemic or hypotensive episodes which are frequently encountered during thiazide therapy. In agreement with the observations of Cangiano,^{5,6} we did not find signs of developing tolerance or

increase in side effects during long-term metolazone therapy. Dosage increase was not required in any of the patients, while in two a daily schedule was reduced to three days per week with continued excellent control. Five of the hypertensive patients have now been well controlled with no complaints of side effects for treatment periods longer than one year.

Metolazone appears to offer advantages over thiazide agents, with respect to potency and prolonged action, often obviating the need for concomitant medications such as reserpine or methyldopa, which tend to be less well tolerated. However, we did find that metolazone could be administered with clonidine or guanethidine, providing combinations that were effective and well tolerated in instances of highly refractory hypertension. Nevertheless, metolazone was effective alone for control of hypertension in 11 of 15 patients treated.

The results in the patients under review suggest that metolazone is a highly useful antihypertensive/diuretic agent in terms of both efficacy and tolerability standards. It appeared to provide an advantageous balance of potency and extended action with an acceptable incidence of side effects. The favorable therapeutic profile indicated by these results is a highly desirable characteristic in the therapy of these conditions.

ACKNOWLEDGEMENT

The author wishes to acknowledge the capable assistance of Norma Wearmouth, R.N.

REFERENCES

The references noted in this paper are available either from the author or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

QUESTIONS-ANSWERS

(Continued from page 470)

tors, because of a doctor surplus, ready and willing to accept salaried positions, and the end of fee-for-service as we know it today. Perhaps most important of all, I believe we will see an increasing emphasis on the doctor's responsibility, not just to preserve life, but to concern himself with the "quality of life." In the pursuit of this appealing creed, we have

already seen at times the diversion of medical skills to an assault on normal processes and normal structures. This can be seen in instances of hormone manipulation, cosmetic surgery, sex-change procedures, vasectomy and tubal ligation, and the killing of normal fetuses. This last will inevitably remove the barrier to the widespread practice of active euthanasia — not just for the terminally ill, but for the aged, the social burden, and maybe even for you and me.

It is also predictable that someday — some distant day — the pendulum will swing back.

Evaluation of Infants For Retrolental Fibroplasia

RONALD V. KEECH, M.D.

WILLIAM E. SCOTT, M.D.

ALLEN ERENBERG, M.D.

Iowa City, Iowa

Practical guidelines are offered for screening and follow-up of infants with retrolental fibroplasia. Examination at a weight of 1500 grams and after 33 weeks gestational age are important. Described here are 26 patients with RLF seen at University Hospitals.

RETROLENTAL FIBROPLASIA (RLF) was first described by T. L. Terry in 1942.¹ For nearly a decade reports appeared in the literature that considered numerous possible etiologic factors. It was not until the early 1950's that investigators began to look seriously at oxygen as a possible cause.

Kinsey and Zacharias,² Gordon,³ and Campbell⁴ all found a correlation between the use of oxygen and the incidence of RLF in the hospitals they studied. Patz and his associates⁵ performed the first controlled nursery study and found a 25% incidence of advanced RLF in the high use oxygen group compared with no RLF in the low oxygen group. Kinsey⁶ and others in a large cooperative study also gave firm evidence incriminating oxygen as the etiologic agent.

On the basis of these reports, the use of oxygen significantly decreased in the late

1950's with a parallel decrease in the incidence of RLF. However, it soon became clear that severe oxygen restriction was harmful for other reasons. Avery and Oppenheimer⁷ demonstrated a higher mortality rate in premature infants born in the late 1950's compared with the late 1940's. McDonald⁸ reported a threefold increase in the incidence of spastic diplegia in infants who received oxygen for less than 11 days compared with a group who received it for a longer period. More recently, the importance of oxygen and assisted ventilation in the treatment of Respiratory Distress Syndrome (RDS) has been stressed.⁹

Due to these factors there has been a progressive shift towards increased oxygen use and many investigators have feared an associated increase in the incidence of RLF.¹⁰ Although accurate figures are difficult to obtain to support this view, it is clear that even with the judicious use of oxygen and the advances in oxygen monitoring techniques, RLF remains a problem.

The purpose of this report is to present the patients with RLF seen at the University of Iowa and to study possible predisposing factors. Our guidelines for evaluation and follow-up of these patients will be discussed.

MATERIALS AND METHODS

At The University of Iowa Hospitals & Clinics approximately 600 new patients are admitted each year to the neonatal care units. We examined all infants for RLF between August 1974 and July 1978 who had received an inspired concentration of oxygen (FiO_2) greater than 0.40 for 2 hours or more. A complete ophthalmologic examination was performed including evaluation of the peripheral retina

The authors are associated with the Departments of Ophthalmology and Pediatrics at The University of Iowa College of Medicine.

TABLE 1
RLF PATIENTS AT THE UNIVERSITY OF IOWA

Patient #	Weight (Gms)	Gestational Age (Weeks)	RDS	Transfers
1	1050	29		X
2	1000	30	X	
3	800	28		
4	1930	37	X	
5	1275	34	X	X
6	1000	28	X	X
7	1450	28	X	
8	1070	28	X	X
9	1050	30		
10	1134	30		X
11	1000	31	X	X
12	990	30		X
13	900	27		
14	900	28	X	
15	1000	30	X	
16	990	28	X	X
17	1200	32	X	X
18	920	28		
19	1620	32	X	
20	2260	32	X	
21	1300	31	X	
22	700	28	X	X
23	940	30	X	
24	1360	28	X	
25	980	28	X	X
26	1010	30	X	X

with indirect ophthalmoscopy and scleral indentation. Follow-up examinations varied depending on the presence and severity of the disease. Most infants were re-examined between one and four months later.

RESULTS

We found a total of 26 new cases of RLF among the patients admitted to The University of Iowa Hospitals during the period studied (Table 1). The birth weights varied between 700-2260 gm. The gestational ages ranged between 27-37 weeks. The oldest infant (#4) was one of the first examined in this series at a time when gestational ages were not routinely recorded. He was thought by some examiners to be more pre-term than 37 weeks. Infants were classified according to the presence of Respiratory Distress Syndrome (RDS) and to their location of birth. Seventy-three per cent of the infants with RLF had RDS. Of the total group, 54 per cent were born at University of Iowa Hospitals.

TABLE 2
RLF PATIENTS AT THE UNIVERSITY OF IOWA

	RDS	Non-RDS	Entire Group
Average birth weight (grams)	1210	978	1206
Average gestational age (weeks)	30.2	28.9	29.8

The average birth weight of the entire group was 1206 gm (Table 2). There was no statistically significant difference in the birth weights and gestational ages of the RDS or non-RDS infants.

Although the information was not available to calculate the incidence of RLF over the entire 4 year period, we were able to determine an approximate incidence in infants under 1500 gm birth weight for the last year of the study. A total of 105 patients were included in this category. Sixty-nine (69%) infants survived and of these, 5 (8%) developed RLF.

COMMENTS

We did not consider oxygen therapy in our study for two reasons. First, oxygen has already been well established as a causative factor in the production of RLF. Second, the multiple variables inherent in the administration and monitoring of oxygen make it extremely difficult to study oxygen therapy retrospectively.

Birth weight has been the most commonly used parameter for evaluating patients with RLF (Table 3). Kingham¹² reviewed 68 cases of RLF and found all but 2 had birth weights of 1600 gm or less. These 2 had minimal signs of RLF. Shahinian¹³ studied 12 infants with RLF all of which had birth weights less than 1650 gm. Mousel¹⁴ found all but one of the 27 patients he studied with RLF to have birth weights of 2000 gm or less. In the largest series reported, Flynn¹⁵ examined 97 infants with RLF between 1969-1974. Of the 82 infants with birth weights listed, 77 (94%) of these were less than 1800 gm. In our series of 26 patients all but 2 had birth weights less than or equal to 1620 gm. Of these, one weighed 1930 gm and the other 2260 gm.

Gestational age, although directly related to birth weight, is itself an indicator of possible RLF (Table 4). In Kinsey's 1956 report,⁶ 7 of 40 infants with RLF had gestational ages of over 33 weeks. This probably reflects the more liberal use of oxygen and the lack of oxygen monitoring at the time. A more recent study from Sweden¹⁶ reported gestational ages up to 40 weeks. In this series however, oxygen monitoring was not reported. In Shahinian's¹³ report, no infant over 33 weeks gestational age developed RLF. In our series we found gestational ages of RLF patients between 27-37 weeks with an average of 30 weeks.

TABLE 3

BIRTH WEIGHTS OF RLF PATIENTS

Study	No. of Patients	Birth Weights
Kingham	68	97% \leq 1600 gm
Shahinian	12	100% \leq 1650 gm
Mousel	27	96% $<$ 2000 gm
Flynn	82	94% $<$ 1800 gm
University of Iowa	26	92% \leq 1620 gm

Based on the information presented we have established some practical guidelines for the screening and follow-up of infants with RLF. Our basic requirements for initial screening are: (1) All infants less than 1500 gm birth weight, (2) All infants less than or equal to 36 weeks gestational age who are exposed to an FiO_2 of 40% or greater for 4 hours or more. In this way, we feel we can screen those infants larger than 1500 gm who are still at high risk to develop RLF. A third, less rigid requirement includes other infants who may not fall into the first of these two groups, but seem to demonstrate an unusually high risk such as those with particularly severe respiratory disease or who demonstrate pulmonary oxygen toxicity.

Another important guideline is the timing of the initial examination to provide the most useful information. We prefer to delay the examination until the infant weighs at least 1500 gm. Infants smaller than this are usually medically unstable and the benefits of an examination at this time are minimal. Another consideration is the clarity of the optical media. Generally, the lack of complete regression of the anterior tunica vasculosa in addition to the haze of the peripheral vitreous in the younger infants makes the examination unsatisfactory prior to 33 weeks gestational age. Finally, it takes a few weeks after cessation or decrease in the oxygen therapy before the retinopathy appears. By the time of their discharge most of the infants will have been off the oxygen long enough for the disease to be identified.

To outline a logical approach for following patients with RLF, the natural history of the disease (Table 5) must be considered. RLF has conveniently been classified into an active and cicatricial phase. The active phase usually occurs over a period of days to weeks. Although the majority of infants with RLF do not experience serious sequelae during this process, severe proliferative RLF may quickly result in

TABLE 4

GESTATIONAL AGES OF RLF PATIENTS

Study	No. of Patients	Gestational Ages
Kinsey (1956)	40	82% (33) \leq 33 wks
Svedborg (1973)	23	96% (22) \leq 34 wks
Shahinian (1978)	12	100% \leq 34 wks
University of Iowa (1978)	26	93% (24) \leq 32 wks

vitreous hemorrhage, glaucoma, or retinal detachment. Following active RLF, regression with cicatrization may occur over weeks to years. This may be demonstrated by such findings as a pale optic disc, dragged retinal vessels, irregular peripheral retinal pigmentation and degeneration, and a localized or total retinal detachment.

Although the etiology is not clear, myopia is frequently associated with RLF. Tasman¹⁷ found 86% of patients with RLF he studied to be myopic. Of these, 65% were greater than 6 diopters. Whatever the mechanism, this degree of myopia contributes to the long term complications of RLF.

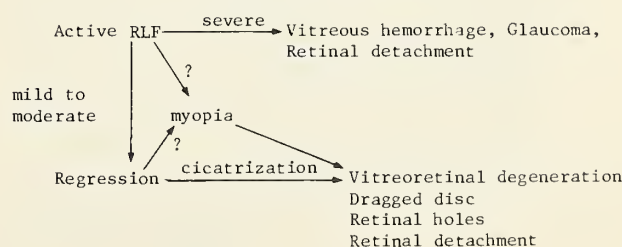
On the basis of the natural history of RLF, we have designed guidelines for following these patients and monitoring their disease. If an infant is free of disease on the initial examination, no further follow-up is necessary. In Flynn's study none of the infants who were normal on the first examination developed RLF. When RLF is noted on the initial examination, the infants are followed at monthly intervals or more frequently, depending on the severity of the disease, until regression or stabilization of the process occurs.

REGULAR MONITORING

Our purpose in screening and following these infants is to monitor for retinal neovas-

TABLE 5

NATURAL HISTORY OF RLF



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TABLETS

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TABLETS

ALDORIL[®] D50

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and 50 mg HydroDIURIL[®] (Hydrochlorothiazide, MSD)

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cularization, vitreous hemorrhages, and retinal detachments. It is equally important to identify significant refractive errors, to prevent amblyopia, and to educate parents. The treatment of acute RLF is controversial and generally not a consideration in the management of these patients. Treatment is rarely indicated because most cases regress spontaneously. In addition, the results of therapy are not well documented. Although there are studies reporting success with cryopexy or photocoagulation, they are highly selective cases with poor controls.^{12, 14, 17, 18} It remains to be resolved whether acute progressive RLF is responsive to any therapy.

The potential long term complications of RLF require continued periodic evaluation. A patient with a history of RLF who has not been followed routinely by an ophthalmologist should be referred for evaluation regardless of the patient's age or lack of symptoms. In Tasman's review of the long term effects of RLF in children, 16 of 69 eyes (23%) had a retinal detachment which was surgically treatable.¹⁹ The average age of the patient at the time of the detachment was 13.5 years.

In summary, 26 patients with RLF seen at the University of Iowa Hospitals & Clinics are presented, and the important predisposing factors reviewed. Based on these parameters guidelines for patient selection, timing of the initial examination, and follow-up are discussed.

REFERENCES

The references noted with this article are available on request either from the authors or the JOURNAL OF THE IOWA MEDICAL SOCIETY.

UPDATE POLICY

An updated policy statement on chiropractic was adopted by the Iowa Medical Society Executive Council in November. The statement is identical to one adopted by the AMA earlier in the year. It describes chiropractic doctrine and comments on relations between physicians and chiropractors. It declares that physicians may refer patients for diagnostic or therapeutic services to another physician, a licensed limited practitioner, or any other provider of health care services permitted by law to furnish such services . . . referral to limited practitioners should be based on their individual competence and ability to perform the services needed by the patient. Member physicians may obtain the full statement on request.

Atypical Carpal Tunnel Syndrome

ARNIS B. GRUNDBERG, M.D.

Des Moines, Iowa

Three cases of atypical carpal tunnel syndrome are noted briefly. They depart from the diagnostic norm somewhat, in fact they reflect up to 50% of the patients seen for this disorder by the author.

THIS PAPER will present those signs and symptoms of carpal tunnel syndrome not commonly known or recognized as being due to that syndrome.

The classical case of carpal tunnel syndrome is in the middle aged female who has numbness and tingling in the median nerve distribution of the hand. At night the hand and wrist wakes her because it burns, tingles and aches. On examination there is decreased sensation in the median nerve distribution of the hand. Tapping with the finger on the volar aspect of the wrist reproduces a tingling (positive Tinel sign). This type of presentation accounts for only about 50% of patients with carpal tunnel syndrome in my experience.

Before presenting examples of "Atypical Carpal Tunnel Syndrome," Phalen's test should be mentioned. This easy test is positive in 90% of patients who have carpal tunnel syndrome. In contrast, the Tinel sign is positive in only about 15% of cases. The Phalen's test is done by flexing the affected wrist acutely, but not forcibly, and holding it there for one min-

ute. Numbness and tingling anywhere in the median nerve distribution signifies a positive test.

The following cases illustrate signs and symptoms of carpal tunnel syndrome that are not commonly recognized.

PRESENTATION OF CASES

Case 1 — A 38-year-old farmer complained of pain in the left upper extremity of nine months duration. The pain started at the wrist and radiated to the elbow and the shoulder. It came at night and interrupted sound sleep. In the daytime it also was present during vigorous use of the upper extremity. Only upon close questioning did the patient admit to having numbness and tingling in the hand. On examination the Phalen's test was positive. There was a mild sensory deficit in the hand in the median nerve distribution. The Tinel sign was negative. The EMG studies revealed slowing of conduction in the median nerve at the wrist. The carpal tunnel was surgically decompressed. The night after surgery the patient reported he slept for the first time in several months without the upper extremity pain waking him. He has had no pain since then.

COMMENT: The pain due to carpal tunnel syndrome can affect the whole left upper extremity and on occasion can radiate to the neck and scapular area.

Case 2 — A 40-year-old housewife presented with a one year history of numbness and tingling only in the right ring and long fingers. The numbness and tingling was present with hard work and woke her at night. This numbness usually was accompanied by aching in the wrist. The referring physician discounted carpal tunnel syndrome because the numbness and tingling involved only the long and ring

The author is in private practice and is associated with Des Moines Orthopaedic Surgeons, P.C.

fingers. On stimulation with a pin there was reduced sensation only over the distal phalanx of the index finger. Phalen's test was positive. The EMG showed changes compatible with carpal tunnel syndrome. The carpal tunnel was decompressed and the patient was relieved of her symptoms.

COMMENT: Carpal tunnel syndrome presenting with numbness and tingling in the long and ring fingers is quite common. It is also common to have decreased sensation only in the long finger and increased sensation to pin prick in the index finger. It is the distal phalanges that show early sensory disturbances on examination and should receive concentration in the sensory examination.

Case 3 — A 25-year-old lady who works on an assembly line complained of clumsiness and weakness of the hand and mild aching in the wrist. She dropped parts while working. She denied pain at night, but occasionally noted some mild numbness in the hand on waking that cleared in a few minutes time. The examination was entirely normal, except that hold-

ing the wrist in flexion for one minute caused numbness and some tingling in the median nerve distribution (positive Phalen's test). The EMG was within normal limits. Other physicians did not think she had carpal tunnel syndrome because of the lack of sensory deficit on examination and the lack of night pain and a normal EMG. The symptoms were relieved by carpal tunnel decompression.

COMMENT: Patients who do repetitive work often complain of clumsiness and weakness while working as the first symptoms of carpal tunnel syndrome. The classical night pain may not be present in these patients. Frequently there is no sensory deficit and the EMG findings show no abnormality.

SUMMARY

So called "atypical" cases of carpal tunnel syndrome are presented. These cases, however, make up about 50% of the patients with carpal tunnel syndrome seen in the practice of this orthopedic physician.

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COMMENTING EDITORIALLY

MARION E. ALBERTS, M.D.
SCIENTIFIC EDITOR

THOUGHTS OF THE SEASON

It is a day of bright sunshine and briskly cold winds. I have chosen to pause among preparations for winter to share a few thoughts. The rose bed is ready for winter; the tulip bulbs await the warmth of spring; the lawnmower is standing aside for the snowblower; the situation appears to be in hand.

Planning ahead, as the slogan has it, is as important with the changing of the seasons as it is with most everything. We need to minimize any undue change in the state of being. For example, while the ground is still free of frost it is a relatively easy task to prepare rose bushes. If there is an absence of planning and some delay, the labors needed to preserve the roses for future seasons are much greater and must be done under less favorable circumstances.

RECERTIFICATION

The competence of physicians is a major and ongoing concern of the American Board of Medical Specialists. In its most recent annual report, the ABMS reaffirmed its dedication to assuring competence.

An ABMS policy statement, revised on March 16, 1978, states in part that "recertification should assure, through periodic evaluations, the physician's continuing competence

Winter need not be a season of gloom just as old age need not be a time of despair and unhappiness. As we arrive at winter, and especially the Christmas interlude, we should think anew about the reasons for this celebration, and the manner in which we express the thoughts of the time.

The yule tree is of pagan origin. The appearance of evergreen just inside a home was to dispel winter's gloom. This custom is thought to have occurred first among the Romans. Mention appears in German literature in 1604, and the practice follows the years to our contemporary use of evergreens in home landscaping as well as at Christmas. Swedes and Norwegians still place small fir trees or branches on the ridge pole of newly built homes in quest of good luck. Japanese pursue good fortune by placing sprigs of evergreen and rice cakes at the entry of their homes on New Year's Day. Legend has it Martin Luther first used candles on the tree to symbolize the Christ Child, the Light of the World, whose birth brightened the sky on the first Christmas eve.

It is traditional to look to Christmas and to the future with gratitude. We need to be prepared to aid those who are less fortunate. We assure our future by providing for the futures of those with whom we live and work. We cannot stand alone for long; faith must be part of our daily lives, a faith in our associates, in our own abilities and an overall faith. This way we prepare for the winter of our life — and the changing of each season along the way.

We wish you a very Happy Holiday Season.
— MEA

in the chosen area of specialty practice." It says further that such recertification should require certified physicians to continue their educational activities to maintain such competency. Individual boards may elect voluntary or mandatory recertification. The purpose of recertification is not to remove a valid certification but to assist the physician in maintaining and documenting his continuing qualifications to practice his specialty.

There are 22 ABMS specialty boards. As of July 1979, 5 had completed at least one recer-

(Please turn to page 484)

tification cycle; 3 had received ABMS approval for their recertification proposals, and 3 have proposals pending. The manner of meeting recertification is left to the individual specialty board. Any of the following criteria may be used: challenge examinations, practice audits, continuing medical education and/or self-assessment tests/syllabuses. The usual recertification interval is 6 years.

To illustrate the varying approaches, the American Board of Family Practice requires an examination, a practice audit and 300 CME hours over 6 years; the American Board of Obstetrics and Gynecology requires an examination and practice audit every 5-7 years; the American Board of Internal Medicine requires only an examination every 6 years with self-assessment optional.

There is no argument with the policy of maintaining one's competency to practice a medical specialty. The physician owes this to his patients and himself. The requirement of recertification, however, in some instances,

may become tedious, time consuming, and expensive. I can see a busy specialist in a remote area finding it necessary to leave his practice at regular intervals to seek CME. There will be occasion when his patients will be without his care.

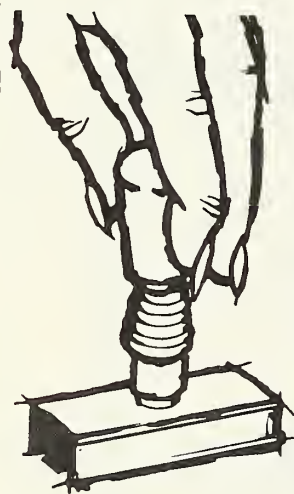
An older physician may feel in his declining years he is less adept at taking formal examinations. Even a highly competent person can become intimidated by such a requirement and may consequently fail an examination.

Peer review is another way to evaluate competence, but personalities are involved here. It is conceivable that an "influential" group of specialists could dominate a hospital staff in such a way to ostracize an "outsider." Safeguards against this are necessary.

Self-assessment examinations (with accompanying syllabus) are practical in that they can be done at individual convenience. The physician is left to decide whether to examine himself without the use of the answer sheet or textbook, or to use the answers closely with the examination. In either instance, there is stimulation of the thought processes and learning ensues. Incidentally, the latest such test from the American Academy of Pediatrics has an evaluation sheet on which the examinee indicates whether each question is *relevant*, *relevant but unclear* or *irrelevant*. Such an evaluation will certainly let the self-assessment provider know the sentiments of the examinee.

In the past many self-assessment examinations have contained questions on a pet subject of someone who has seen one case of "xyz syndrome." It may be of little or no concern to anyone else. Incidentally, I have always thought students should submit "report cards" on teachers and professors, in the same manner the student is evaluated on his performance. When such occurs the student must realize teachers have less productive days too, and an evaluation should not be based on a single performance.

CME, peer review, *et al*, are with us. How each is accomplished is of paramount importance. Our reactions must be verbalized, we need to be involved in making the whole process as satisfactory and acceptable as possible. Like many things in our lives now, if we do not enter our suggestions, and we do not like what we get, we have no one to blame but ourselves. The idea of CME and recertification is good; the process needs ongoing attention. — MEA



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OUR MAN ON EDUCATION

RICHARD M. CAPLAN, M.D.

EDUCATION CAN BE "TRAVELOUS"

We're all brainwashed to believe that old saw: travel is educational. And I don't mean to deny it. In the nature of my work, however, it also works the other way: education can be "travelous" (or travelal or travelful). I seem obliged to move around to lots of places where education is considered, planned, moulded, presented, implemented, absorbed, cancelled, decried, forgotten, budgeted, sought, measured, philosophized about, vilified, meditated upon, exorcised, exalted, entrenched, reversed, supplemented, nullified, evoked — add more if you wish; my mental thesaurus runs dry even though I'm sure education either performs or is performed upon by the action of more verbs than these.

Much of my educationally-induced travel is by air. And though the air is often called an ocean, the metaphor has increased power

Dr. Caplan is Associate Dean for Continuing Medical Education at The University of Iowa College of Medicine.

ACADEMY AWARD

Richard M. Caplan, M.D., associate dean, continuing medical education, University of Iowa, was presented the "Educator of the Year" award by the Iowa Academy of Family Physicians at its annual meeting in November.

when one sits behind a large window at a great airport looking at the activity seething outside. It is like watching the ocean bottom at some rich feeding ground. The dominant feature is the large slender airplane-fish, sliding effortlessly to and from sites for ingesting or disgorging passengers. (The "digestive process" implied by those words is inefficient and not gastrointestinal, for the passengers are belched back out the entering portals, as fish many times spit back what they have just mouthed. Although not digested, those passengers often may be altered profoundly by the trip.) These huge fish are of many colors and shapes: some pointed, some blunt, some with tails elevated or depressed; snouts lean or humped; locomotor apparatus carried in different places; even underslung ovipositors that descend to place motley-hued eggs upon the platforms of helping organisms that carry away the fecund lumps. Other organisms scurry every which way, some resembling chains of huge streptococci, others more like diplococci. Still others look like crabs and lobsters, circling vertiginously, either knowing something of their own purposes and ways that I don't know, or suffering from malfunctioning organs of balance.

Such man-made displays, seemingly random or chaotic in their moment-by-moment flittings — upward, downward, sideways, around — are really purposeful, but one must look to a higher level of consciousness to divine that purpose. I often wonder, as I watch the busy churning of the CME world around me, how much of it is instinctual rather than intellectual, more a kind of Brownian motion than purposeful pursuit.

You, also, may travel for educational reasons, as I do. If your next trip to the big city doesn't include the pleasure of a visit to the aquarium in the city center, enjoy its man-made imitation at the airport.

Dr. Caplan has been responsible for CME at the U. of I. since 1969. The office he directs now provides more than 180 formal CME programs annually at the University and in 30 or more sites around the state. Registrations at these events total more than 8,500 and involve some 700 faculty members.

OKAY IOWA SHP

The five-year (1980-85) State Health Plan for Iowa was approved in November by the Statewide Health Coordinating Council. Adoption of a plan of this type is a federal requirement. The Iowa SHP has chapters on priorities for health and health care; disease prevention and detection and community health education; primary care; acute care; long-term care, and health care costs.

Written comments on the SHP were submitted in October by the Iowa Medical Society. This IMS input concerned primarily acute and primary care and was generally well received.

The SHP is described as an evolving document to be in a continuous state of revision. However, after the annual updating next year to produce the 1981-86 Iowa SHP, recent federal amendments will put the revision process into a three-year cycle.

Also of major consequence in the development of health planning documents is the forthcoming preparation of a State Medical Facilities Plan. This effort is likely to be incorporated into next year's SHP. Needs identified in the SMFP may go alongside certificate of need criteria in the evaluation of expansion or replacement applications.

TOP RECOGNITION

Frederic M. Ashler, M.D., Hamburg, was a recent national finalist in the "Family Physician of the Year" competition cosponsored by the American Academy of Family Physicians and *Good Housekeeping* magazine. Eight candidates were chosen as finalists from nominees submitted by states.

Dr. Ashler has practiced in Hamburg since 1959. He is a member of the State Board of Health and a past-president of the Iowa Academy of Family Physicians.

October 1979 Morbidity Report

Disease	Oct. 1979 Total	1979 to Date	1978 to Date	Most Oct. Cases Reported From These Counties
Amebiasis	3	77	145	Boone
Brucellosis	1	7	15	Dubuque
Chickenpox	112	7254	5831	Linn
Cytomegalovirus	1	10	15	Des Moines
Eaton's Agent infection	4	39	115	Palk
Encephalitis, viral	12	62	27	Dubuque
Erythema infectiosum	10	1081	50	Linn
Gastroenteritis (GIV)	1618	15547	13280	Linn, Johnson
Giardiasis	1	34	26	Des Moines
Hepatitis, A	12	165	120	Palk
Hepatitis, B	3	81	84	Scott
type unspecified	9	60	52	Marshall, Palk
Herpes simplex	8	64	60	Johnson
Herpes Zoster	0	1	70	—
Histoplasmosis	0	2	3	—
Infectious mononucleosis	19	432	985	Pattawattamie
Influenza, lab confirmed	0	34	202	—
Influenza-like illness (URI)	3244	45966	720	Linn, Palk
Meningitis				
aseptic	24	79	29	Johnson
bacterial	9	97	52	Palk
meningococcal	1	11	14	Chickasaw
Mumps	2	235	150	Plymouth
Pertussis	1	3	3	Pattawattamie
Rabies in animals	18	159	116	Keokuk
Rheumatic fever	0	10	28	—
Rubella				
(German measles)	0	52	59	—
Rubeola (measles)	0	16	57	—
Salmonella	20	148	158	Palk
Shigella	4	66	54	Morion
Tuberculosis				
fatal ill	0	58	89	—
bact. pas.	0	51	64	—
Veneral diseases:				
Gonorrhea	574	4919	4597	Black Hawk, Palk
P. & S. Syphilis	0	28	30	—

Laboratory Virus Diagnosis Without Specified Clinical Syndrome: Scarlet Fever — 2, Taylor, Palk; Echovirus — 43, Scattered; Typhoid — 1, Palk; Blastomycosis — 1, Palk; Rocky Mountain Spotted Fever — 1, Palk; Filariasis — 1, Black Hawk; Typhoid — 1, Palk; Reye Syndrome — 1, Palk.

ABOUT IOWA PHYSICIANS

Dr. Raja Akbar is acting superintendent of the Independence Mental Health Institute. Dr. Akbar has been affiliated with the hospital since 1972 when he began his psychiatric residency. Prior to his new appointment, Dr. Akbar was clinical director of the Independence facility. . . . **Dr. Don Young**, Des Moines, was guest speaker at the annual meeting of the Jasper County Republican Women. Dr. Young discussed the breast cancer detection project which he has headed at Iowa Lutheran Hospital in Des Moines since 1974. . . . **Dr. Michael Stein**, Des Moines, was guest speaker at a recent meeting of the Iowa Chapter of the Myasthenia Gravis Foundation, Inc. . . . **Dr. Joel D. Teigland**, Des Moines, has been appointed to a three-year term on the Board of Regents of the American College of Allergists. Dr. Teigland is a past member of the board of governors of the American Association of Certified Allergists; and has served on the Ethics Committee and Credentials Committee of the American Academy of Allergy. . . . **Dr. Dale A. Harding**, Eagle Grove, was guest speaker at a recent meeting of the Iowa Schizophrenia Association. Dr. Harding's topic was "Update on the Treatment of Depression and Schizophrenia." . . . **Dr. James L. Hartje**, Sioux City, has been certified a diplomate of the American Board of Gastroenterology. Dr. Hartje has recently joined **Drs. R. J. Harrington, D. J. Wagner and M. L. Zucker in Sioux City.**

Dr. John Tyrrell, Manchester, has been appointed to an Ad Hoc Committee on Health Planning/Council on Medical Service of the American Medical Association. Dr. Tyrrell is current president of the Iowa Health Systems Agency and a member of the Executive Com-

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mittee of the State Health Coordinating Council. . . . **Dr. Richard M. Caplan**, associate dean, continuing medical education, U. of I. College of Medicine, recently was appointed to a newly created Committee on Accreditation of Continuing Medical Education/American Medical Association. The committee will evaluate organizations and institutions providing CME. . . . **Dr. Richard Lawton** is establishing a surgical practice in Hampton at the first of the year. Formerly with the University of Iowa, Dr. Lawton went to Texas Tech University in 1976 to initiate a kidney transplant program. He is a former chairman of the IMS Committee on Organ Transplantation and a past-president of the Kidney Foundation of Iowa. . . . **Dr. Ronald K. Grooters**, Des Moines, has been named a fellow in the American College of Cardiology. Announcement of the appointment was made by **Dr. Richard M. Schieken**, Iowa City, ACC governor for Iowa.

Dr. S. Donald Zaentz, Ames, discussed chemotherapy and various modes of combined therapy at the October meeting of the Wright

County Medical Society. . . . **Dr. Carl Aschoff**, director, Cedar Rapids Medical Education Program, has been appointed to Residency Assistance Program Panel of Consultants. Supporting organizations for the RAPPC are the American Academy of Family Physicians; American Board of Family Practice; Society of Teachers of Family Medicine and the Family Health Foundation of America. Dr. Aschoff will be a consultant and adviser for family residency programs across the state. . . . **Dr. Lucas S. Van Orden**, director, chemical dependency unit, Mt. Pleasant Mental Health Institute, was guest speaker at the recent annual meeting of the Northeast Iowa Mental Health Center. Dr. Van Orden discussed alcohol and drug abuse and their relationship to mental health. . . . **Dr. U. John Collignon**, Council Bluffs physician for 27 years, retired from active practice in October. Dr. Collignon received the M.D. degree and served his internal medicine residency at Indiana University. He located in Council Bluffs in 1952. He and Mrs. Collignon plan to move to Sante Fe, New Mexico. . . . **Dr. Peter R. Jochimsen**, chief of oncology services at University Hospitals in Iowa City, and **Dr. Michael P. Corder**, associate professor of medicine, U. of I. College of Medicine, were guest speakers at a recent Keokuk Area Hospital program on management of patients with carcinoma of the breast.

DEATHS

Dr. Charles A. Nicoll, 77, Panora physician for over 40 years, died October 16 at Guthrie County Hospital in Guthrie Center. Dr. Nicoll received the M.D. degree from Northwestern University. He was a past president of the Iowa Academy of Family Practice.

Dr. John L. Klein, 67, Muscatine, died October 9 at his home. Dr. Klein received the M.D. degree from the U. of I. College of Medicine and interned at Montreal General Hospital in Canada. He began his medical practice with his father and later was associated with his brother for 32 years, retiring in 1970. Dr. Klein was a 40-year member of Rotary International; medical advisor for the Muscatine County Tuberculosis Association for 25 years; and past president and 10-year member of the Muscatine County Museum of Fine Arts.

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In The Public Interest

On Physician Advertising



IN LATE OCTOBER the Iowa Medical Society sent 3,000-plus copies of its 1979-80 Membership Directory around the state. In addition to member physicians, the Directory was forwarded to Iowa hospitals, libraries and chambers of commerce. It's obvious from its title this volume contains principally the alphabetic and geographic listings of doctors affiliated with the IMS.

Further, however, it is a limited compendium of reference information about such entities as the Board of Medical Examiners, Board of Health, Iowa medical specialty groups, voluntary health agencies, etc.

Also prominent in the 1979-80 IMS Directory is a blue-colored section which contains over 80 informational messages (advertisements if you prefer) provided by various Iowa medical clinics and physicians' offices. The messages in this 16-page supplement carry information about medical specialties, types of services, clinic names, addresses, phone numbers, etc. On its introductory page the section notes its purpose (a) to aid physicians in making referrals, and (b) to help Iowans who use the Directory to find particular medical services in a particular Iowa community. Space in the section was made available on an optional basis to interested physician members.

Coincidentally, October brought forth a ruling from the Federal Trade Commission that the Principles of Medical Ethics (POME) of the American Medical Association unlawfully restrict competitive advertising by physicians. The FTC ruling directs the AMA to eliminate all anti-competitive advertising principles in its POME.

That the first three paragraphs of this discussion relate to the preceding one is hopefully apparent. The recent distribution of the IMS Directory is at least one tangible effort by the medical profession to get pertinent and useful information to the public. In no way is the IMS Directory represented as the ultimate in describing professional medical services, but it certainly has some merit in this regard.

Interestingly, and perhaps contradictorily, the FTC, in addition to admonishing the profession for restricting competitive advertising, said in its October 24 ruling there is nothing to prohibit the AMA from "enforcing reasonable ethical guidelines governing the conduct of its members with respect to representations, that would be false or deceptive . . . or with respect to uninvited, in-person solicitation of actual or potential patients who, because of their particular circumstances, are vulnerable to undue influence."

Thus, on the one hand, the FTC declares physician advertising has been restrained by the profession. Then, on the other hand, in a conciliatory and more realistic vein, the agency says, "the AMA has a valuable and unique role to play with respect to deceptive advertising and oppressive forms of solicitation by physicians."

The AMA has disclosed it intends to appeal the FTC ruling to the U. S. Court of Appeals, even though pleasure was expressed over recognition by the Commission that the profession has a "valuable and unique" role to play in identifying deceptive advertising.

This *In the Public Interest* page has said before that the POME do not proscribe advertising, but rather they condemn the solicitation of patients. The former is the process of making information known to the public. The public should know the names of physicians, types of practice, office locations, office hours and other useful information. The term solicitation suggests effort to gain patients through statements or claims that (1) contain testimonials, (2) are intended or likely to create inflated or unjustified expectations of favorable results, (3) are self-laudatory and imply skills superior to others in a specialty of practice, or (4) have incorrect or incomplete statements sufficient to cause the average person to misunderstand or be deceived.

So, while the FTC takes its position, and physicians rightly support their long-standing professional contentions regarding advertising, it's probably fair to conclude that Stanley Slickfingers, M.D., who advertises the *Sharpest Scalpel South of St. Paul and the Lowest Prices Around* won't attract many Iowans; they simply don't select medical care on this basis.

December 1979

Journal of the Iowa Medical Society



THINGS YOU SHOULD KNOW

HEALTH PLANNING CONFAB

The complexities of health planning will get a going-over this month. A September 27 Iowa Medical Society briefing will give interested physicians a chance to discuss and appraise the state's health planning framework. In keeping with a request of the 1979 IMS House of Delegates, the session has among its goals (a) strategy development to assure physician participation in HP activities, and (b) identification of ways in which the Society can aid physicians working at HP tasks. More info on the Thursday afternoon meeting at IMS Headquarters is available by calling 1/800/422-3070.

BC/BS CHANGES OCCUR

David Neugent and William Recknor, top administrative officers for Blue Cross and Blue Shield, respectively, have stepped down from their positions to speed along the selection of a single chief executive officer to head both organizations. Work forces of the two corporations were merged in 1972 with the appointment of one CEO planned to follow at the appropriate time. Boards of both bodies decided in August that time was at hand. Robert Beckwith is serving as chief operating officer for both bodies until the new CEO is designated.

CON STANDARDS OKAYED

Certificate of Need standards covering radiation therapy and financial feasibility were adopted by the Statewide Health Coordinating Council in August. The FF standards apply presumably to all CON's, in addition to those standards that relate to a specific service, e.g., CT, RT, etc. The IMS is seeking clarification on the applicability of FF standards to a single piece of physician-purchased equipment costing more than \$150,000. Further approval of these standards must come from the Board of Health and Administrative Rules Committee.

DRUG DISPENSING

IMS legal counsel has been asked to analyze a recent Attorney General's opinion which indicates dispensing of a medication is not a delegable task and is restricted specifically to either a pharmacist or a physician, dentist, veterinarian or podiatrist. This recent opinion is contrary to one issued several years ago that said a physician can delegate authority to dispense to a nurse or other personnel.

HF COUNCIL ADDS TWO

The five-consumer-member Health Facilities Council now includes two new persons -- former Iowa Senator Minette Doderer of Iowa City and Gage Parker of Shenandoah. Appointments to the council are made by the Governor. The HFC decides on all certificate of need applications.

POSSIBLE USE TAX

Iowa physicians are reminded when medical supplies and/or equipment are purchased from a totally out-of-state vendor, say through a mail order business, the purchaser is subject to a 3% use tax. The use tax becomes due in the calendar quarter the property is received; a penalty and interest accrue when payment of the use tax is not made. State sales tax is applicable when the vendor has any office, salesperson, or other facility in the state. This of course serves in lieu of the use tax.

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THINGS YOU SHOULD KNOW

CHIROPRACTIC SUIT

Delays have been granted at least until October 10 to the several defendants named in a suit filed by the Health Equalization Committee of the Iowa Chiropractic Society. The 10 chiropractors on the HEC allege that the IMS and the other defendants have violated Federal antitrust laws and have interfered with the plaintiff's business relationships. The suit asks the court to allow actual damages of \$35 million and punitive damages of \$70 million.

IMPAIRED PHYSICIAN

Hope is the new IMS Impaired Physicians Assistance Program can become functional early in 1980. Approval of the program was given by the Executive Council in late August. The voluntary program is meant to aid physicians with such problems as alcoholism and other drug dependence, mental illness, aging, etc. Under the program a small group of "physician advocates" will be sought to encourage evaluation and treatment.

IMS/AETNA LIABILITY

Additional improvements in the IMS/Aetna Liability Insurance Program are expected to be announced formally next month. Presentation of the 1979 Annual Report will be made in November, first to the Medico-Legal Committee, then to the IMS Executive Council. Participation in the program has surpassed 1,000 member physicians. Informational programs on current liability issues are available to county medical societies through the IMS/Aetna Program. Contact the IMS for info.

STATE HEALTH PLAN

The Preliminary 1980-85 State Health Plan for Iowa was distributed in September by the IMS to county medical society presidents. This 225-page document is a joint product of the State Health Planning and Development Agency (SHPDA) and the Statewide Health Coordinating Council (SHCC). It provides a basis for ongoing discussion of state health issues. Five public hearings on the Plan are occurring in October with comments from these hearings to be considered prior to its likely adoption by the SHCC in November. Copies of the Plan are available on request.

DISPENSING RESPONSE

In September the IMS filed a request with Attorney General Tom Miller that he reconsider his department's opinion that physicians who dispense may not delegate the performance of this task to competent individuals acting under the supervision of the physician or at his/her direction. The 14-page IMS request asks the AG to revise his opinion to make it consistent with the common law which supports the right of physicians to delegate these tasks.

LONG-TERM CARE

Physician responsibilities in long-term care facilities were discussed at an early October meeting of the IMS Committee on Medical Practice in Health Facilities and Homes. This further consideration was stimulated partly by criticism directed to the IMS that physician coverage for patients in long-term care facilities is a problem. The IMS meeting also involved reps of the Iowa Health Care Association (nursing homes), State Health Department and Iowa Foundation for Medical Care.

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THINGS YOU SHOULD KNOW

OVER A MILLION

A \$529,521 additional dividend will go to member physicians insured under the IMS/Aetna Liability Insurance Program. This good news was part of the 1979 annual report submitted by Aetna November 15. This third dividend since inception of the program brings to more than one million dollars the amount returned to insured members. The dividend is first to include interest earned by Aetna from premium income -- a move encouraged by the IMS. Other 1980 program improvements included a 20% premium reduction for physicians in their first practice year and 10% for the second year. Rates for 1980 will remain unchanged.

OKAY NEW BENEFITS

Fee collection services of a widely-recognized national firm will soon be available to interested IMS members. An IMS sponsored program through the I.C. System, Inc., was recommended by the Committee on Member Services and approved November 15 by the Executive Council. A mailing on the program will go to all Society members in the near future.

DUES STATEMENTS

Dues statements for 1980 were mailed in November to members of 85 county medical societies for which the IMS provides billing services. Prompt payment of these dues is much appreciated. Budget meetings of the IMS board of trustees will occur in December.

1980 RATE DROP

Participants in the IMS health coverage provided through Blue Cross/Blue Shield will see a drop in monthly rates in 1980. The high-benefit family contract will decline from \$97.75 to \$90.95. Groups wishing to do so may add new benefits under the Delta Dental Plan next year. This coverage will be optional but must be taken by all members of a covered group.

APPROVE STANDARDS

Approval was given in November by the Statewide Health Coordinating Council (SHCC) to certificate of need (CON) standards covering obstetrical, pediatric, and neonatal intensive care units. These CON standards apply to future bed modification and equipment acquisition. An amendment to the standards approved by the SHCC lowers by 5% required obstetrical bed occupancy levels as follows: (200/299 births per year from 60% to 55%) (100/199 births per year from 55% to 50%) (100/Fewer - 45%). Further study of these levels will be pursued by the SHCC in the coming year -- at the urging of the Iowa Hospital Association.

PHARMACY REGS

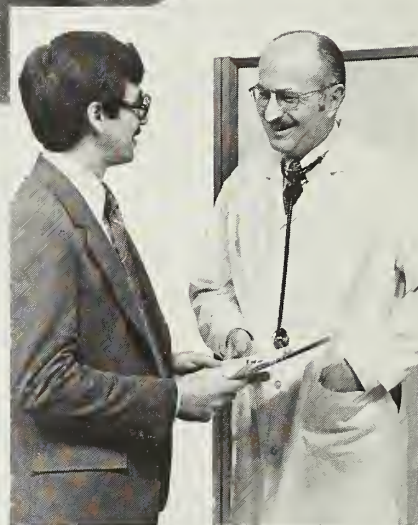
Rules applicable to employment or rental agreements between physicians and pharmacists have been refiled by the State Board of Pharmaceutical Examiners. These proposed rules address the ethics of such arrangements. IMS officials are again examining the matter in a belief this is not likely a subject for rule making.

ASSEMBLY RETURNS

Iowa lawmakers return to their statehouse seats January 14. Two special elections in November were won by Republicans. Gary Baugher, Ankeny, will fill a Senate seat vacated by Earl Willits. Robert Renken, Aplington, takes a House chair left by Cooper Evans, an aspirant for the Grassley Congressional post. The Republican edge is now 29/21 in the Senate and 56/44 in the House.



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